BlueCross BlueShield of Montana

Recommended Clinical Review (Predetermination), Post-Service Review and Non-Covered 2023 Commercial Benefit Procedure Code List

Posted December 2023

EXCEPT AS OTHERWISE NOTED IN THE DATE COLUMN, THESE CODES ARE EFFECTIVE ON OR BEFORE JANUARY 1, 2023.

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

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

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

To make a request for a Recommended Clinical Review (Predetermination), refer to our Utilization Management information on our website. You can also submit a request through Availity. https://www.availity.com/

Procedure Code Groups	Procedure Code Group Description
Medical Policy Criteria (MP Criteria)	Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Highlighted procedure/service in this code group may require Prior Authorization per contract agreement.
Non Covered	Procedures/services not covered by the Plan. Not subject to pre-service review.
Experimental, Investigational, Unproven (EIU)	EIU: Procedure/service not 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.

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

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

Code	Code Description	Code Group & Description	Effective Date	Ending Date	Updates
00640	ANESTH SPINE MANIPULATION	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
00797	ANESTH SURGERY FOR OBESITY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
01941	ANES NEUROMD/NTRVRT CRV/THRC	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	5/15/2023	Retire effective 05/15/2023

01942	ANES NEUROMD/NTRVRT LMBR/SAC	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	5/15/2023	Retire effective 05/15/2023
11055	Trim Skin Lesion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	9/30/2023	Retire effective 09/30/2023
11056	Trim Skin Lesions 2 To 4	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	9/30/2023	Retire effective 09/30/2023
11057	Trim Skin Lesions Over 4	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	9/30/2023	Retire effective 09/30/2023
11719	Trim Nail(S) Any Number	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	9/30/2023	Retire effective 09/30/2023
11720	DEBRIDE NAIL 1-5	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	9/30/2023	Retire effective 09/30/2023
11721	DEBRIDE NAIL 6 OR MORE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	9/30/2023	Retire effective 09/30/2023
11920	Correct Skin Color 6.0 Cm/<	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) 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 (Predetermination) 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 (Predetermination) 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 (Predetermination) 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 (Predetermination) 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 (Predetermination) 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 (Predetermination) to avoid post-service review.	_	_	_
11971	RMVL TIS XPNDR WO INSJ IMPLT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
11980	IMPLANT HORMONE PELLET(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
11981	INSERTION DRUG DLVR IMPLANT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
11982	Remove Drug Implant Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
11983	REMOVE/INSERT DRUG IMPLANT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) to avoid post-service review.	4/1/2023	_	Add effective 04/01/2023
15272	Skin Sub Graft T/A/L Add-On	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	4/1/2023	_	Add effective 04/01/2023
15273	Skin Sub Grft T/Arm/Lg Child	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	4/1/2023	_	Add effective 04/01/2023
15274	Skn Sub Grft T/A/L Child Add	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	4/1/2023	_	Add effective 04/01/2023
15275	Skin Sub Graft Face/Nk/Hf/G	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	4/1/2023	_	Add effective 04/01/2023
15276	Skin Sub Graft F/N/Hf/G Addl	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	4/1/2023	_	Add effective 04/01/2023
15277	Skn Sub Grft F/N/Hf/G Child	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	4/1/2023	_	Add effective 04/01/2023
15278	Skn Sub Grft F/N/Hf/G Ch Add	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	4/1/2023	_	Add effective 04/01/2023
15758	FREE FASCIAL FLAP MICROVASC	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) 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 (Predetermination) 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 (Predetermination) to avoid post-service review.	_	_	_
15773	GRFG AUTOL FAT LIPO 25 CC/<	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
15774	GFRG AUTOL FAT LIPO EA ADDL	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
15775	HAIR TRNSPL 1-15 PUNCH GRFTS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) to avoid post-service review.	_	_	_
15780	DERMABRASION TOTAL FACE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
15781	DERMABRASION SEGMENTAL FACE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
15782	DERMABRASION OTHER THAN FACE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
15783	DERMABRASION SUPRFL ANY SITE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_

15788	CHEMICAL PEEL FACE EPIDERM	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
15789	CHEMICAL PEEL FACE DERMAL	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
15792	CHEMICAL PEEL NONFACIAL	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
15793	CHEMICAL PEEL NONFACIAL	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
15820	REVISION OF LOWER EYELID	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
15821	REVISION OF LOWER EYELID	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
15822	REVISION OF UPPER EYELID	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
15823	REVISION OF UPPER EYELID	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
15824	REMOVAL OF FOREHEAD WRINKLES	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
15825	REMOVAL OF NECK WRINKLES	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
15826	REMOVAL OF BROW WRINKLES	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
15828	REMOVAL OF FACE WRINKLES	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
15829	REMOVAL OF SKIN WRINKLES	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
15830	EXC SKIN ABD	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
15832	EXCISE EXCESSIVE SKIN THIGH	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
15833	EXCISE EXCESSIVE SKIN LEG	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
15834	EXCISE EXCESSIVE SKIN HIP	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
15835	EXCISE EXCESSIVE SKIN BUTTCK	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
15836	EXCISE EXCESSIVE SKIN ARM	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) 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 (Predetermination) to avoid post-service review.	_	_	_
15839	EXCISE EXCESS SKIN & TISSUE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) to avoid post-service review.	_	_	_
15876	SUCTION LIPECTOMY HEAD&NECK	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
15877	SUCTION LIPECTOMY TRUNK	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
15878	SUCTION LIPECTOMY UPR EXTREM	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
15879	SUCTION LIPECTOMY LWR EXTREM	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) to avoid post-service review.	_	_	_
17107	DESTRUCTION OF SKIN LESIONS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
17108	DESTRUCTION OF SKIN LESIONS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) to avoid post-service review.	_	_	_
17380	HAIR REMOVAL BY ELECTROLYSIS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) to avoid post-service review.	_	_	_
19300	REMOVAL OF BREAST TISSUE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
19303	MAST SIMPLE COMPLETE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
19316	SUSPENSION OF BREAST	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
19318	Breast Reduction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
19325	BREAST AUGMENTATION W/IMPLT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_

19328	RMVL INTACT BREAST IMPLANT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
19330	RMVL RUPTURED BREAST IMPLANT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) 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 (Predetermination) to avoid post-service review.	_	_	_
19350	BREAST RECONSTRUCTION	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
19355	CORRECT INVERTED NIPPLE(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) to avoid post-service review.	_	_	_
19370	REVJ PERI-IMPLT CAPSULE BRST	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) to avoid post-service review.	_	_	_
19380	REVJ RECONSTRUCTED BREAST	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
19396	DESIGN CUSTOM BREAST IMPLANT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
19499	UNLISTED PROCEDURE BREAST	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
19499	UNLISTED PROCEDURE BREAST	Unlisted: Procedure/service 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 (Predetermination) 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).	_	_	_
20693	ADJUST BONE FIXATION DEVICE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	9/30/2023	Retire effective 09/30/2023
20694	REMOVE BONE FIXATION DEVICE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	9/30/2023	Retire effective 09/30/2023
20696	COMP MULTIPLANE EXT FIXATION	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	9/30/2023	Retire effective 09/30/2023
20697	COMP EXT FIXATE STRUT CHANGE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	10/31/2023	Retire effective 10/31/2023
20932	OSTEOART ALGRFT W/SURF & B1	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_

20933	HEMICRT INTRCLRY ALGRFT PRTL	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
20934	INTERCALARY ALGRFT COMPL	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
20974	ELECTRICAL BONE STIMULATION	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
20975	ELECTRICAL BONE STIMULATION	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
20979	US BONE STIMULATION	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
20982	ABLATE BONE TUMOR(S) PERQ	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
20983	ABLATE BONE TUMOR(S) PERQ	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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.	_	_	_
21010	INCISION OF JAW JOINT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
21025	EXCISION OF BONE LOWER JAW	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
21026	EXCISION OF FACIAL BONE(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
21050	REMOVAL OF JAW JOINT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
21060	REMOVE JAW JOINT CARTILAGE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
21070	REMOVE CORONOID PROCESS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
21073	MNPJ OF TMJ W/ANESTH	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
21083	PREPARE FACE/ORAL PROSTHESIS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
21085	PREPARE FACE/ORAL PROSTHESIS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
21089	UNLISTED MAXLFCL PROSTH PX	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
21110	INTERDENTAL FIXATION	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
21120	RECONSTRUCTION OF CHIN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_

21121	RECONSTRUCTION OF CHIN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
21122	RECONSTRUCTION OF CHIN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
21123	RECONSTRUCTION OF CHIN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
21125	Augmentation Lower Jaw Bone	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
21127	Augmentation Lower Jaw Bone	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
21141	LEFORT I-1 PIECE W/O GRAFT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
21142	LEFORT I-2 PIECE W/O GRAFT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
21143	LEFORT I-3/> PIECE W/O GRAFT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
21145	Lefort I-1 Piece W/ Graft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
21146	Lefort I-2 Piece W/ Graft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
21147	Lefort I-3/> Piece W/ Graft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
21150	Lefort Ii Anterior Intrusion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
21151	Lefort Ii W/Bone Grafts	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
21154	Lefort Iii W/O Lefort I	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
21155	Lefort Iii W/ Lefort I	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
21159	Lefort Iii W/Fhdw/O Lefort I	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
21160	Lefort Iii W/Fhd W/ Lefort I	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
21188	Reconstruction Of Midface	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
21193	RECONST LWR JAW W/O GRAFT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
21194	RECONST LWR JAW W/GRAFT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_

21195	RECONST LWR JAW W/O FIXATION	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
21196	RECONST LWR JAW W/FIXATION	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
21198	RECONSTR LWR JAW SEGMENT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
21199	RECONSTR LWR JAW W/ADVANCE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
21206	Reconstruct Upper Jaw Bone	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
21208	Augmentation Of Facial Bones	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
21209	Reduction Of Facial Bones	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
21210	FACE BONE GRAFT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
21215	LOWER JAW BONE GRAFT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
21240	RECONSTRUCTION OF JAW JOINT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
21242	RECONSTRUCTION OF JAW JOINT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
21243	RECONSTRUCTION OF JAW JOINT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
21244	RECONSTRUCTION OF LOWER JAW	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
21245	RECONSTRUCTION OF JAW	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
21246	RECONSTRUCTION OF JAW	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
21248	RECONSTRUCTION OF JAW	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	9/30/2023	Retire effective 09/30/2023
21282	REVISION OF EYELID	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
21299	UNLISTED CRANFCL&MAXLFCL PX	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
21480	RESET DISLOCATED JAW	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
21485	RESET DISLOCATED JAW	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
21490	REPAIR DISLOCATED JAW	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service 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 (Predetermination) to avoid post-service review.	_	_	_
21740	Reconstruction Of Sternum	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
21742	Repair Stern/Nuss W/O Scope	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
21743	Repair Sternum/Nuss W/Scope	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) to avoid post-service review.	_	_	_
22510	PERQ CERVICOTHORACIC INJECT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
22511	PERQ LUMBOSACRAL INJECTION	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
22512	VERTEBROPLASTY ADDL INJECT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
22513	PERQ VERTEBRAL AUGMENTATION	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
22514	PERQ VERTEBRAL AUGMENTATION	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
22515	PERQ VERTEBRAL AUGMENTATION	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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).	_	_	_
22548	ARTHRD ANT TORAL/XORAL C1-C2	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
22551	ARTHRD ANT NTRBDY CERVICAL	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
22552	ARTHRD ANT NTRBD CERVICAL EA	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
22554	ARTHRD ANT NTRBD MIN DSC CRV	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
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).	_	_	_
22590	ARTHRD PST TQ CRANIOCERVICAL	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_

22595	ARTHRD PST TQ ATLAS-AXIS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
22600	ARTHRD PST TQ 1NTRSPC CRV	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
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).	_	_	_
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 (Predetermination) to avoid post-service review.	_	_	_
23929	UNLISTED PROCEDURE SHOULDER	Unlisted: Procedure/service 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 (Predetermination) to avoid post-service review.	_	_	_
24999	UNLISTED PX HUMERUS/ELBOW	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
25999	UNLISTED PX FOREARM/WRIST	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
26341	MANIPULAT PALM CORD POST INJ	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
26989	UNLISTED PX HANDS/FINGERS	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
27096	INJECT SACROILIAC JOINT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
27275	MANIPULATION OF HIP JOINT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
27279	ARTHRD SI JT PERQ/MIN NVAS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
27280	ARTHR SI JT OPN B1GRF INSTRM	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	Retire effective 09/30/2023
27299	UNLISTED PX PELVIS/HIP JOINT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
27299	UNLISTED PX PELVIS/HIP JOINT	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
27412	AUTOCHONDROCYTE IMPLANT KNEE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
27415	OSTEOCHONDRAL KNEE ALLOGRAFT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_

27416	OSTEOCHONDRAL KNEE AUTOGRAFT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
27599	UNLISTED PX FEMUR/KNEE	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
27702	RECONSTRUCT ANKLE JOINT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
27703	RECONSTRUCTION ANKLE JOINT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
27704	Removal Of Ankle Implant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
27899	UNLISTED PX LEG/ANKLE	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
28446	OSTEOCHONDRAL TALUS AUTOGRFT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service 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.	_	_	_
29799	UNLISTED PX CASTING/STRPG	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
29800	JAW ARTHROSCOPY/SURGERY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
29804	JAW ARTHROSCOPY/SURGERY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
29862	HIP ARTHR0 W/DEBRIDEMENT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
29866	AUTGRFT IMPLNT KNEE W/SCOPE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
29867	ALLGRFT IMPLNT KNEE W/SCOPE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
29868	MENISCAL TRNSPL KNEE W/SCPE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
29914	HIP ARTHRO W/FEMOROPLASTY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
29915	HIP ARTHRO ACETABULOPLASTY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
29916	HIP ARTHRO W/LABRAL REPAIR	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
29999	UNLISTED PX ARTHROSCOPY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
29999	UNLISTED PX ARTHROSCOPY	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
30120	REVISION OF NOSE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_

30150	PARTIAL REMOVAL OF NOSE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
30400	RECONSTRUCTION OF NOSE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
30410	RECONSTRUCTION OF NOSE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
30420	RECONSTRUCTION OF NOSE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
30430	REVISION OF NOSE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
30435	REVISION OF NOSE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
30450	REVISION OF NOSE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service 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	_	Add effective 01/01/2023
30801	ABLATE INF TURBINATE SUPERF	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
30802	ABLATE INF TURBINATE SUBMUC	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
30999	UNLISTED PROCEDURE NOSE	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
31295	Nsl/Sins Ndsc Surg Max Sins	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
31296	NSL/SINS NDSC SURG FRNT SINS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
31297	NSL/SINS NDSC SURG SPHN SINS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
31298	Nsl/Sins Ndsc Surg Frnt&Sphn	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
31299	UNLISTED PX ACCESSORY SINUS	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
31599	UNLISTED PROCEDURE LARYNX	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
31634	Bronch W/Balloon Occlusion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
31648	BRONCHIAL VALVE REMOV INIT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
31649	BRONCHIAL VALVE REMOV ADDL	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_

31660	BRONCH THERMOPLSTY 1 LOBE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
31661	BRONCH THERMOPLSTY 2/> LOBES	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
31899	UNLISTED PX TRACHEA BRONCHI	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
32553	Ins Mark Thor For Rt Perq	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
32850	DONOR PNEUMONECTOMY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
32851	LUNG TRANSPLANT SINGLE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
32852	LUNG TRANSPLANT WITH BYPASS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
32853	LUNG TRANSPLANT DOUBLE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
32854	LUNG TRANSPLANT WITH BYPASS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
32855	PREPARE DONOR LUNG SINGLE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
32856	PREPARE DONOR LUNG DOUBLE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
32994	ABLATE PULM TUMOR PERQ CRYBL	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) to avoid post-service review.	_	_	_
32999	UNLISTED PX LUNGS & PLEURA	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
33202	INSERT EPICARD ELTRD OPEN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
33203	INSERT EPICARD ELTRD ENDO	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
33211	INSERT CARD ELECTRODES DUAL	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
33213	INSERT PULSE GEN DUAL LEADS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
33216	INSERT 1 ELECTRODE PM-DEFIB	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
33217	INSERT 2 ELECTRODE PM-DEFIB	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
33218	REPAIR LEAD PACE-DEFIB ONE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_

33220	REPAIR LEAD PACE-DEFIB DUAL	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
33223	RELOCATE POCKET FOR DEFIB	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
33224	INSERT PACING LEAD & CONNECT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
33225	L VENTRIC PACING LEAD ADD-ON	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
33230	INSRT PULSE GEN W/DUAL LEADS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
33231	INSRT PULSE GEN W/MULT LEADS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
33240	INSRT PULSE GEN W/SINGL LEAD	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
33241	REMOVE PULSE GENERATOR	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
33243	REMOVE ELTRD/THORACOTOMY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
33244	REMOVE ELCTRD TRANSVENOUSLY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
33249	INSJ/RPLCMT DEFIB W/LEAD(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
33262	RMVL& REPLC PULSE GEN 1 LEAD	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
33263	RMVL & RPLCMT DFB GEN 2 LEAD	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
33264	RMVL & RPLCMT DFB GEN MLT LD	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) 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 (Predetermination) 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 (Predetermination) to avoid post-service review.	_	_	_
33270	Ins/Rep Subq Defibrillator	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
33271	Insj Subq Impltbl Dfb Elctrd	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
33272	RMVL OF SUBQ DEFIBRILLATOR	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_

33273	REPOS PREV IMPLTBL SUBQ DFB	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) 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 (Predetermination) 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 (Predetermination) to avoid post-service review.	_	_	_
33286	RMVL SUBQ CAR RHYTHM MNTR	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
33289	TCAT IMPL WRLS P-ART PRS SNR	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
33340	Perq Clsr Tcat L Atr Apndge	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
33361	REPLACE AORTIC VALVE PERQ	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
33362	REPLACE AORTIC VALVE OPEN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
33363	REPLACE AORTIC VALVE OPEN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
33364	REPLACE AORTIC VALVE OPEN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
33365	REPLACE AORTIC VALVE OPEN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
33366	TRCATH REPLACE AORTIC VALVE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
33367	REPLACE AORTIC VALVE W/BYP	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
33368	REPLACE AORTIC VALVE W/BYP	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
33369	REPLACE AORTIC VALVE W/BYP	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
33370	TCAT PLMT&RMVL CEPD PERQ	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
33418	REPAIR TCAT MITRAL VALVE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
33419	REPAIR TCAT MITRAL VALVE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
33477	IMPLANT TCAT PULM VLV PERQ	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_

33542	Removal Of Heart Lesion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
33548	RESTORE/REMODEL VENTRICLE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
33894	EVASC ST RPR THRC/AA ACRS BR	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	9/30/2023	Retire effective 09/30/2023
33895	EVASC ST RPR THRC/AA X CRSG	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	9/30/2023	Retire effective 09/30/2023
33897	PERQ TRLUML ANGP NT/RECR COA	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
33927	IMPLTJ TOT RPLCMT HRT SYS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
33928	RMVL & RPLCMT TOT HRT SYS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
33929	Rmvl Rplcmt Hrt Sys F/Trnspl	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
33930	REMOVAL OF DONOR HEART/LUNG	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
33933	PREPARE DONOR HEART/LUNG	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
33935	TRANSPLANTATION HEART/LUNG	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
33940	REMOVAL OF DONOR HEART	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
33944	PREPARE DONOR HEART	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
33945	TRANSPLANTATION OF HEART	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
33975	Implant Ventricular Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
33976	Implant Ventricular Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
33977	REMOVE VENTRICULAR DEVICE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
33978	REMOVE VENTRICULAR DEVICE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
33979	Insert Intracorporeal Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
33980	REMOVE INTRACORPOREAL DEVICE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_

33981	Replace Vad Pump Ext	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
33982	Replace Vad Intra W/O Bp	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
33983	Replace Vad Intra W/Bp	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
33990	Insj Perq Vad L Hrt Arterial	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
33991	Insj Perq Vad L Hrt Artl&Ven	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
33992	Rmvl Perq Left Heart Vad	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
33993	Reposg Perq R/L Hrt Vad	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
33995	INSJ PERQ VAD R HRT VENOUS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
33997	RMVL PERQ RIGHT HEART VAD	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
33999	UNLISTED PX CARDIAC SURGERY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
33999	UNLISTED PX CARDIAC SURGERY	Unlisted: Procedure/service 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 (Predetermination) 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 (Predetermination) to avoid post-service review.	_	_	_
36468	NJX SCLRSNT SPIDER VEINS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) 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 (Predetermination) 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 (Predetermination) 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 (Predetermination) to avoid post-service review.	_	_	_

36478	ENDOVENOUS LASER 1ST VEIN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
36479	ENDOVENOUS LASER VEIN ADDON	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) 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 (Predetermination) to avoid post-service review.	_	_	_
36511	Apheresis Wbc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
36516	Apheresis Immunoads Slctv	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
36522	PHOTOPHERESIS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
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	_	Add effective 01/01/2023
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	_	Add effective 01/01/2023
37215	TRANSCATH STENT CCA W/EPS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) to avoid post-service review.	_	_	_
37217	STENT PLACEMT RETRO CAROTID	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
37218	STENT PLACEMT ANTE CAROTID	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
37241	VASC EMBOLIZE/OCCLUDE VENOUS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
37242	VASC EMBOLIZE/OCCLUDE ARTERY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
37243	VASC EMBOLIZE/OCCLUDE ORGAN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
37244	VASC EMBOLIZE/OCCLUDE BLEED	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
37500	ENDOSCOPY LIGATE PERF VEINS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
37501	UNLISTED VASC ENDOSCOPY PX	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
37700	REVISE LEG VEIN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) 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 (Predetermination) 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 (Predetermination) to avoid post-service review.	_	_	_
37760	LIGATE LEG VEINS RADICAL	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
37761	LIGATE LEG VEINS OPEN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) to avoid post-service review.	_	_	_
37766	PHLEB VEINS - EXTREM 20+	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
37780	REVISION OF LEG VEIN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
37785	LIGATE/DIVIDE/EXCISE VEIN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
37788	Revascularization Penis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
37790	PENILE VENOUS OCCLUSION	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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.	_	_	_
38204	BL DONOR SEARCH MANAGEMENT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
38205	HARVEST ALLOGENEIC STEM CELL	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
38207	CRYOPRESERVE STEM CELLS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
38208	THAW PRESERVED STEM CELLS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
38209	WASH HARVEST STEM CELLS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) to avoid post-service review.	_	_	_
38211	TUMOR CELL DEPLETE OF HARVST	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
38212	RBC DEPLETION OF HARVEST	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
38213	PLATELET DEPLETE OF HARVEST	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_

38214	VOLUME DEPLETE OF HARVEST	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
38215	HARVEST STEM CELL CONCENTRTE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
38232	BONE MARROW HARVEST AUTOLOG	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
38240	TRANSPLT ALLO HCT/DONOR	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
38242	TRANSPLT ALLO LYMPHOCYTES	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
38243	TRANSPLJ HEMATOPOIETIC BOOST	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
38308	INCISION OF LYMPH CHANNELS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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.	_	_	_
41120	Partial Removal Of Tongue	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
41512	TONGUE SUSPENSION	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service 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.	_	_	_
41899	UNLISTED PX DENTALVLR STRUX	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
42140	EXCISION OF UVULA	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
42145	REPAIR PALATE PHARYNX/UVULA	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service 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.	_	_	_
43192	Esophagoscp Rig Trnso Inject	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_

43201	Esoph Scope W/Submucous Inj	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service 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).	_	_	_
43210	EGD ESOPHAGOGASTRC FNDOPLSTY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
43229	ESOPHAGOSCOPY LESION ABLATE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
43236	UPPR GI SCOPE W/SUBMUC INJ	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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).	_	_	_
43253	EGD US TRANSMURAL INJXN/MARK	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
43257	EGD W/THRML TXMNT GERD	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
43270	EGD LESION ABLATION	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
43284	LAPS ESOPHGL SPHNCTR AGMNTJ	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
43285	Rmvl Esophgl Sphnctr Dev	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
43289	UNLISTED LAPS PX ESOPH	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
43289	UNLISTED LAPS PX ESOPH	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
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	_	Add effective 01/01/2023
43291	EGD FLX TRNSORL RMVL 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	_	Add effective 01/01/2023
43497	TRANSORL LWR ESOPHGL MYOTOMY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
43499	UNLISTED PROCEDURE ESOPHAGUS	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
43632	Removal Of Stomach Partial	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	6/1/2023	_	Add effective 06/01/2023
43633	REMOVAL OF STOMACH PARTIAL	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
43644	LAP GASTRIC BYPASS/ROUX-EN-Y	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) to avoid post-service review.	_	_	_

43647	LAP IMPL ELECTRODE ANTRUM	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
43648	LAP REVISE/REMV ELTRD ANTRUM	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
43659	UNLISTED LAPS PX STOMACH	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
43770	LAP PLACE GASTR ADJ DEVICE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) to avoid post-service review.	_	_	_
43772	LAP RMVL GASTR ADJ DEVICE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
43773	LAP REPLACE GASTR ADJ DEVICE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) to avoid post-service review.	_	_	_
43775	LAP SLEEVE GASTRECTOMY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
43842	V-BAND GASTROPLASTY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) to avoid post-service review.	_	_	_
43845	GASTROPLASTY DUODENAL SWITCH	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
43846	GASTRIC BYPASS FOR OBESITY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) to avoid post-service review.	_	_	_
43848	REVISION GASTROPLASTY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
43881	IMPL/REDO ELECTRD ANTRUM	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
43882	REVISE/REMOVE ELECTRD ANTRUM	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
43886	REVISE GASTRIC PORT OPEN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
43887	REMOVE GASTRIC PORT OPEN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
43888	CHANGE GASTRIC PORT OPEN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
43999	UNLISTED PROCEDURE STOMACH	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_

44132	ENTERECTOMY CADAVER DONOR	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
44133	ENTERECTOMY LIVE DONOR	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
44135	INTESTINE TRANSPLNT CADAVER	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
44136	INTESTINE TRANSPLANT LIVE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
44137	REMOVE INTESTINAL ALLOGRAFT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
44238	UNLISTED LAPS PX INTESTINE	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
44705	PREPARE FECAL MICROBIOTA	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
44715	PREPARE DONOR INTESTINE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
44720	PREP DONOR INTESTINE/VENOUS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
44721	PREP DONOR INTESTINE/ARTERY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
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.	_	_	_
47133	REMOVAL OF DONOR LIVER	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
47135	TRANSPLANTATION OF LIVER	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
47140	PARTIAL REMOVAL DONOR LIVER	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
47141	PARTIAL REMOVAL DONOR LIVER	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
47142	PARTIAL REMOVAL DONOR LIVER	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_

47143	PREP DONOR LIVER WHOLE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
47144	PREP DONOR LIVER 3-SEGMENT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
47145	PREP DONOR LIVER LOBE SPLIT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
47146	PREP DONOR LIVER/VENOUS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
47147	PREP DONOR LIVER/ARTERIAL	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) to avoid post-service review.	_	_	_
47371	LAPARO ABLATE LIVER CRYOSURG	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
47379	UNLISTED LAPS PX LIVER	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
47380	OPEN ABLATE LIVER TUMOR RF	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
47381	Open Ablate Liver Tumor Cryo	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
47382	PERCUT ABLATE LIVER RF	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
47383	PERQ ABLTJ LVR CRYOABLATION	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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.	_	_	_
47999	UNLISTED PX BILIARY TRACT	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
48160	PANCREAS REMOVAL/TRANSPLANT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
48550	DONOR PANCREATECTOMY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
48551	PREP DONOR PANCREAS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
48552	PREP DONOR PANCREAS/VENOUS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
48554	TRANSPL ALLOGRAFT PANCREAS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
48556	REMOVAL ALLOGRAFT PANCREAS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service 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.	_	_	_
49411	Ins Mark Abd/Pel For Rt Perq	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
49412	Ins Device For Rt Guide Open	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service 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.	_	_	_
50250	CRYOABLATE RENAL MASS OPEN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
50300	REMOVE CADAVER DONOR KIDNEY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
50320	REMOVE KIDNEY LIVING DONOR	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
50323	PREP CADAVER RENAL ALLOGRAFT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
50325	PREP DONOR RENAL GRAFT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
50327	PREP RENAL GRAFT/VENOUS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
50328	PREP RENAL GRAFT/ARTERIAL	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
50329	PREP RENAL GRAFT/URETERAL	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
50340	REMOVAL OF KIDNEY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
50360	TRANSPLANTATION OF KIDNEY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
50365	TRANSPLANTATION OF KIDNEY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
50370	REMOVE TRANSPLANTED KIDNEY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
50541	LAPARO ABLATE RENAL CYST	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
50542	LAPARO ABLATE RENAL MASS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
50547	LAPARO REMOVAL DONOR KIDNEY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
50549	UNLISTED LAPS PX RENAL	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
50592	PERC RF ABLATE RENAL TUMOR	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_

50593	PERC CRYO ABLATE RENAL TUM	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
50949	UNLISTED LAPS PX URETER	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
51715	ENDOSCOPIC INJECTION/IMPLANT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
51999	UNLISTED LAPS PX BLADDER	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
52287	Cystoscopy Chemodenervation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
52327	CYSTOSCOPY INJECT MATERIAL	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
52441	CYSTOURETHRO W/IMPLANT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
52442	CYSTOURETHRO W/ADDL IMPLANT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
53451	TPRNL BALO CNTNC DEV BI	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
53452	TPRNL BALO CNTNC DEV UNI	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
53453	TPRNL BALO CNTNC DEV RMVL EA	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
53454	TPRNL BALO CNTNC DEV ADJMT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
53855	INSERT PROST URETHRAL STENT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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.	_	_	_
54125	REMOVAL OF PENIS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
54200	TREATMENT OF PENIS LESION	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
54205	TREATMENT OF PENIS LESION	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
54235	Penile Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
54240	PENIS STUDY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
54360	Penis Plastic Surgery	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_

54400	INSERT SEMI-RIGID PROSTHESIS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
54401	INSERT SELF-CONTD PROSTHESIS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
54405	INSERT MULTI-COMP PENIS PROS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
54406	REMOVE MUTI-COMP PENIS PROS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
54408	REPAIR MULTI-COMP PENIS PROS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
54410	REMOVE/REPLACE PENIS PROSTH	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
54411	REMOV/REPLC PENIS PROS COMP	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
54415	REMOVE SELF-CONTD PENIS PROS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
54416	REMV/REPL PENIS CONTAIN PROS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
54417	REMV/REPLC PENIS PROS COMPL	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
54660	REVISION OF TESTIS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
54699	UNLISTED LAPS PX TESTIS	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
54900	FUSION OF SPERMATIC DUCTS	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
54901	FUSION OF SPERMATIC DUCTS	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
55400	Repair Of Sperm Duct	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
55559	UNLSTD LAPS PX SPRMATIC CORD	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
55706	PROSTATE SATURATION SAMPLING	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
55870	Electroejaculation	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
55873	CRYOABLATE PROSTATE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
55876	Place Rt Device/Marker Pros	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) to avoid post-service review.	_	_	_
55899	UNLISTED PX MALE GENITAL SYS	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
55970	SEX TRANSFORMATION M TO F	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) to avoid post-service review.	_	_	_
56700	PARTIAL REMOVAL OF HYMEN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
56805	REPAIR CLITORIS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
56810	REPAIR OF PERINEUM	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
57291	CONSTRUCTION OF VAGINA	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
57292	CONSTRUCT VAGINA WITH GRAFT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
57295	Revise Vag Graft Via Vagina	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
57296	REVISE VAG GRAFT OPEN ABD	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
57335	REPAIR VAGINA	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
57426	REVISE PROSTH VAG GRAFT LAP	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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.	_	_	_
58674	Laps Abltj Uterine Fibroids	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
58679	UNLISTED LAPS PX OVIDCT OVRY	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
58750	REPAIR OVIDUCT	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
58752	Revise Ovarian Tube(S)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
58970	Retrieval Of Oocyte	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
58974	Transfer Of Embryo	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
58976	Transfer Of Embryo	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
58999	UNLISTED PX FML GENITAL SYS	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
59072	UMBILICAL CORD OCCLUD W/US	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) to avoid post-service review.	_	_	_
59076	Fetal Shunt Placement W/Us	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_

59897	UNLISTED FETAL INVAS PX W/US	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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.	_	_	_
60699	UNLISTED PX ENDOCRINE SYSTEM	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
60699	UNLISTED PX ENDOCRINE SYSTEM	Unlisted: Procedure/service 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).	_	_	_
61635	INTRACRAN ANGIOPLSTY W/STENT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
61645	PERQ ART M-THROMBECT &/NFS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
61650	Evasc Prlng Admn Rx Agnt 1St	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
61651	Evasc Prlng Admn Rx Agnt Add	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
61736	LITT ICR 1 TRAJ 1 SMPL LES	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
61737	LITT ICR MLT TRJ MLT/CPLX LS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
61850	IMPLANT NEUROELECTRODES	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
61860	IMPLANT NEUROELECTRODES	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
61863	IMPLANT NEUROELECTRODE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
61864	IMPLANT NEUROELECTRDE ADDL	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
61867	IMPLANT NEUROELECTRODE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
61868	IMPLANT NEUROELECTRDE ADDL	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
61880	REVISE/REMOVE NEUROELECTRODE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
61885	INSRT/REDO NEUROSTIM 1 ARRAY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_

61886	IMPLANT NEUROSTIM ARRAYS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
61888	REVISE/REMOVE NEURORECEIVER	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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).	_	_	_
62380	NDSC DCMPRN 1 NTRSPC LUMBAR	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
63052	LAM FACETC/FRMT ARTHRD LUM 1	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
63053	LAM FACTC/FRMT ARTHRD LUM EA	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
64505	N Block Spenopalatine Gangl	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
64553	IMPLANT NEUROELECTRODES	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
64561	IMPLANT NEUROELECTRODES	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
64566	Neuroeltrd Stim Post Tibial	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
64568	OPN IMPLTJ CRNL NRV NEA&PG	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
64569	REVISE/REPL VAGUS N ELTRD	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
64570	REMOVE VAGUS N ELTRD	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
64581	OPN IMPLTJ NEA SACRAL NERVE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
64582	OPN MPLTJ HPGLSL NSTM ARY PG	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
64583	Rev/Rplct Hpglsl Nstm Ary Pg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
64584	Rmvl Hpglsl Nstim Ary Pg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
64615	Chemodenerv Musc Migraine	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_

64624	DSTRJ NULYT AGT GNCLR NRV	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
64625	RF ABLTJ NRV NRVTG SI JT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
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).	_	_	_
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).	_	_	_
64633	DESTROY CERV/THOR FACET JNT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
64634	DESTROY C/TH FACET JNT ADDL	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
64635	DESTROY LUMB/SAC FACET JNT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
64636	DESTROY L/S FACET JNT ADDL	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
64640	INJECTION TREATMENT OF NERVE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
64716	REVISION OF CRANIAL NERVE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
64732	INCISION OF BROW NERVE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
64734	INCISION OF CHEEK NERVE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
64771	SEVER CRANIAL NERVE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
64999	UNLISTED PX NERVOUS SYSTEM	Unlisted Procedure; May require Prior Authorization per contract agreement.	_	_	_
65710	Corneal Transplant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
65730	Corneal Transplant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
65750	Corneal Transplant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
65755	Corneal Transplant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
65756	Corneal Trnspl Endothelial	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
65757	Prep Corneal Endo Allograft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_

65760	REVISION OF CORNEA	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
65765	Revision Of Cornea	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
65767	CORNEAL TISSUE TRANSPLANT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
65770	REVISE CORNEA WITH IMPLANT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
65771	Radial Keratotomy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
65772	CORRECTION OF ASTIGMATISM	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
65775	CORRECTION OF ASTIGMATISM	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
65778	Cover Eye W/Membrane	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
65779	COVER EYE W/MEMBRANE SUTURE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
65780	OCULAR RECONST TRANSPLANT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) 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 (Predetermination) 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 (Predetermination) 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 (Predetermination) 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 (Predetermination) to avoid post-service review.	_	_	_
66183	INSERT ANT DRAINAGE DEVICE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
66184	Revision Of Aqueous Shunt	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
66185	Revise Aqueous Shunt Eye	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
66989	XCPSL CTRC RMVL CPLX INSJ 1+	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) 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.	_	_	_
67027	Implant Eye Drug System	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_

67028	Injection Eye Drug	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
67299	UNLISTED PX POSTERIOR SEGMNT	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
67345	DESTROY NERVE OF EYE MUSCLE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service 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 (Predetermination) to avoid post-service review.	_	_	_
67901	REPAIR EYELID DEFECT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
67902	REPAIR EYELID DEFECT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
67903	REPAIR EYELID DEFECT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
67904	REPAIR EYELID DEFECT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
67906	REPAIR EYELID DEFECT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
67908	REPAIR EYELID DEFECT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
67909	REVISE EYELID DEFECT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
67911	REVISE EYELID DEFECT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
67912	CORRECTION EYELID W/IMPLANT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
67916	REPAIR EYELID DEFECT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
67917	REPAIR EYELID DEFECT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
67923	REPAIR EYELID DEFECT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
67924	REPAIR EYELID DEFECT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
67950	REVISION OF EYELID	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	_	Add effective 01/01/2023
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.	_	_	_

68841	INSJ RX ELUT IMPLT LAC CANAL	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
68899	UNLISTED PX LACRIMAL SYSTEM	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
69090	PIERCE EARLOBES	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
69300	REVISE EXTERNAL EAR	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
69399	UNLISTED PX EXTERNAL EAR	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
69705	NPS SURG DILAT EUST TUBE UNI	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
69706	NPS SURG DILAT EUST TUBE BI	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
69710	IMPLANT/REPLACE HEARING AID	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
69711	REMOVE/REPAIR HEARING AID	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) to avoid post-service review.	_	_	_
69716	IMPL OI IMPLT SK TC ESP<100	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
69717	Temple Bone Implant Revision	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) to avoid post-service review.	_	_	_
69726	RMV NTR OI IMPLT SKL PRQ ESP	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
69727	RMV NTR OI IMP SK TC ESP<100	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
69728	RMV NTR OI IMP SK TC>=100	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2023	_	Add effective 01/01/2023
69729	IMPL OI IMPLT SK TC ESP>=100	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2023	_	Add effective 01/01/2023
69730	RPLC OI IMPLT SK TC ESP>=100	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2023	_	Add effective 01/01/2023
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 (Predetermination) to avoid post-service review.	_	_	_
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.	_	_	_

75571	CT HRT W/O DYE W/CA TEST	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
75894	X-Rays Transcath Therapy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
76120	CINE/VIDEO X-RAYS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
76125	CINE/VIDEO X-RAYS ADD-ON	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service 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.	_	_	_
76940	US GUIDE TISSUE ABLATION	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
76948	Echo Guide Ova Aspiration	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
76999	ECHO EXAMINATION PROCEDURE	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
77013	Ct Guide For Tissue Ablation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
77022	MRI GDN PARNCHYMA TISS ABLTJ	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
77089	TBS DXA CAL W/I&R FX RISK	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
77090	TBS TECHL PREP&TRANSMIS DATA	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
77091	TBS TECHL CALCULATION ONLY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
77092	TBS I&R FX RSK QHP	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
77261	RADIATION THERAPY PLANNING	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	4/30/2023	Retire effective 04/30/2023
77262	RADIATION THERAPY PLANNING	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
77263	RADIATION THERAPY PLANNING	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
77293	RESPIRATOR MOTION MGMT SIMUL	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
77299	UNLISTED PX THER RAD TX PLNG	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
77299	UNLISTED PX THER RAD TX PLNG	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_

77332	RADIATION TREATMENT AID(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
77333	RADIATION TREATMENT AID(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
77334	RADIATION TREATMENT AID(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
77399	UNLISTED PX MED RADJ PHYSICS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service 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	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
77499	UNLISTED PX THER RAD TX MGMT	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
77799	UNLISTED PX CLIN BRACHYTX	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
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.	_	_	_
78429	MYOCRD IMG PET 1 STD W/CT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
78430	MYOCRD IMG PET RST/STRS W/CT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
78431	MYOCRD IMG PET RST&STRS CT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
78432	MYOCRD IMG PET 2RTRACER	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
78433	MYOCRD IMG PET 2RTRACER CT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
78434	Aqmbf Pet Rest & Rx Stress	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
78459	MYOCRD IMG PET SINGLE STUDY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
78491	MYOCRD IMG PET 1STD RST/STRS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
78492	MYOCRD IMG PET MLT RST&STRS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service 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.	_	_	_
78835	RP QUAN MEAS SINGLE AREA	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
78999	UNLISTED MISC PX DX NUC MED	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
79445	Nuclear Rx Intra-Arterial	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
79999	RP THERAPY UNLISTED PX	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
80145	DRUG ASSAY ADALIMUMAB	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
80230	DRUG ASSAY INFLIXIMAB	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
80280	DRUG ASSAY VEDOLIZUMAB	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service 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.	_	_	_
81105	HPA-1 GENOTYPING	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
81106	HPA-2 GENOTYPING	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
81107	HPA-3 GENOTYPING	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
81108	HPA-4 GENOTYPING	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
81109	HPA-5 GENOTYPING	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
81110	HPA-6 GENOTYPING	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
81111	HPA-9 GENOTYPING	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
81112	HPA-15 GENOTYPING	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
81161	Dmd Dup/Delet Analysis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
81206	Bcr/Abl1 Gene Major Bp	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
81207	Bcr/Abl1 Gene Minor Bp	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_

81241	F5 Gene	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
81243	Fmr1 Gene Detection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	9/30/2023	Retire effective 09/30/2023
81329	SMN1 GENE DOS/DELETION ALYS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	9/30/2023	Retire effective 09/30/2023
81420	Fetal Chrmoml Aneuploidy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	9/30/2023	Retire effective 09/30/2023
81479	UNLISTED MOLECULAR PATHOLOGY	Unlisted Procedure; May require Prior Authorization per contract agreement.	_	_	_
81490	Autoimmune Rheumatoid Arthr	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
81500	ONCO (OVAR) TWO PROTEINS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
81503	Onco (Ovar) Five Proteins	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
81507	Fetal Aneuploidy Trisom Risk	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
81535	Oncology Gynecologic	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	4/30/2023	Retire effective 04/30/2023; check PA list
81536	Oncology Gynecologic	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	4/30/2023	Retire effective 04/30/2023; check PA list
81538	Oncology Lung	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
81539	Oncology Prostate Prob Score	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
81560	TRNSPLJ PD LVR&BWL CD154+CLL	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
81599	UNLISTED MAAA	Unlisted Procedure; May require Prior Authorization per contract agreement.	_	_	_
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).	_	_	_
82653	EL-1 FECAL QUANTITATIVE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	6/30/2023	Retire effective 06/30/2023
82777	Galectin-3	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_

83006	Growth Stimulation Gene 2	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
83529	ASAY OF INTERLEUKIN-6 (IL-6)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	1/1/2022	Retired prior to start date of 1/1/2022
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).	_	_	_
84999	UNLISTED CHEMISTRY PROCEDURE	Unlisted Procedure; May require Prior Authorization per contract agreement.	_	_	_
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).	_	_	_
86051	AQUAPORIN-4 ANTB ELISA	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	4/30/2023	Retire effective 04/30/2023
86052	AQUAPORIN-4 ANTB CBA EACH	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	4/30/2023	Retire effective 04/30/2023
86053	AQAPRN-4 ANTB FLO CYTMTRY EA	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	4/30/2023	Retire effective 04/30/2023
86294	IMMUNOASSAY TUMOR QUAL	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
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	_	Add effective 06/01/2023
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).	_	_	_
86352	Cell Function Assay W/Stim	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	9/30/2023	Retire effective 09/30/2023

86353	LYMPHOCYTE TRANSFORMATION	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
86362	MOG-IGG1 ANTB CBA EACH	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	4/30/2023	Retire effective 04/30/2023
86363	MOG-IGG1 ANTB FLO CYTMTRY EA	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	4/30/2023	Retire effective 04/30/2023
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	_	Add effective 06/01/2023
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	_	Add effective 06/01/2023
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	_	Add effective 06/01/2023
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	_	Add effective 06/01/2023
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.	_	_	_
86950	Leukacyte Transfusion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
86999	UNLISTED TRANSFUSION MED PX	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
87505	NFCT AGENT DETECTION GI	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
87506	IADNA-DNA/RNA PROBE TQ 6-11	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) 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.	_	_	_
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.	_	_	_
88099	UNLISTED NECROPSY (AUTOPSY)	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
88121	CYTP URINE 3-5 PROBES CMPTR	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	9/30/2023	Retire effective 09/30/2023
88199	UNLISTED CYTOPATHOLOGY PX	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
88240	CELL CRYOPRESERVE/STORAGE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
88241	FROZEN CELL PREPARATION	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
88245	CHROMOSOME ANALYSIS 20-25	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
88248	CHROMOSOME ANALYSIS 50-100	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
88249	CHROMOSOME ANALYSIS 100	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
88261	CHROMOSOME ANALYSIS 5	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
88263	CHROMOSOME ANALYSIS 45	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
88264	CHROMOSOME ANALYSIS 20-25	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
88271	CYTOGENETICS DNA PROBE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	4/30/2023	Retire effective 04/30/2023
88272	CYTOGENETICS 3-5	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	4/30/2023	Retire effective 04/30/2023
88273	CYTOGENETICS 10-30	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	4/30/2023	Retire effective 04/30/2023

88274	CYTOGENETICS 25-99	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	4/30/2023	Retire effective 04/30/2023
88275	CYTOGENETICS 100-300	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	4/30/2023	Retire effective 04/30/2023
88283	CHROMOSOME BANDING STUDY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	4/30/2023	Retire effective 04/30/2023
88285	CHROMOSOME COUNT ADDITIONAL	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	9/30/2023	Retire effective 09/30/2023
88289	CHROMOSOME STUDY ADDITIONAL	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	4/30/2023	Retire effective 04/30/2023
88291	CYTO/MOLECULAR REPORT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	4/30/2023	Retire effective 04/30/2023
88299	UNLISTED CYTOGENETIC STUDY	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
88375	OPTICAL ENDOMICROSCPY 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.	_	_	_
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.	_	_	_
89250	Cultr Oocyte/Embryo <4 Days	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
89251	Cultr Oocyte/Embryo <4 Days	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
89253	Embryo Hatching	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
89254	Oocyte Identification	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
89255	Prepare Embryo For Transfer	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
89257	Sperm Identification	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
89258	CRYOPRESERVATION EMBRYO(S)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
89259	CRYOPRESERVATION SPERM	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
89260	Sperm Isolation Simple	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
89261	Sperm Isolation Complex	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
89264	Identify Sperm Tissue	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
89268	Insemination Of Oocytes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
89272	Extended Culture Of Oocytes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
89280	Assist Oocyte Fertilization	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
89281	Assist Oocyte Fertilization	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_

89290	Biopsy Oocyte Polar Body	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
89291	Biopsy Oocyte Polar Body	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
89329	Sperm Evaluation Test	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
89330	Evaluation Cervical Mucus	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
89331	Retrograde Ejaculation Anal	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
89335	CRYOPRESERVE TESTICULAR TISS	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
89337	CRYOPRESERVATION OOCYTE(S)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
89342	STORAGE/YEAR EMBRYO(S)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
89343	STORAGE/YEAR SPERM/SEMEN	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
89344	STORAGE/YEAR REPROD TISSUE	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
89346	STORAGE/YEAR OOCYTE(S)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
89352	THAWING CRYOPRESRVED EMBRYO	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
89353	THAWING CRYOPRESRVED SPERM	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
89354	THAW CRYOPRSVRD REPROD TISS	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
89356	THAWING CRYOPRESRVED OOCYTE	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.	_	_	_
90287	BOTULINUM ANTITOXIN	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
90288	BOTULISM IG IV	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
90378	RSV MAB IM 50MG	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
90393	VACCINA IG IM	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
90399	UNLISTED IMMUNE GLOBULIN	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
90476	ADENOVIRUS VACCINE TYPE 4	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
90477	ADENOVIRUS VACCINE TYPE 7	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
90584	Dengue Vacc Quad 2 Dose Subq	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
90664	Laiv Vacc Pandemic Intranasl	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
90676	RABIES VACCINE ID	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
90678	RSV VACC PREF BIVALENT IM	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	5/30/2023	Add effective 01/01/2023 Retire effective 05/30/2023

90749	UNLISTED VACCINE/TOXOID	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
90846	FAMILY PSYTX W/O PT 50 MIN	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
90867	TCRANIAL MAGN STIM TX PLAN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) to avoid post-service review.	_	_	_
90869	TCRAN MAGN STIM REDETEMINE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
90870	ELECTROCONVULSIVE THERAPY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	12/31/2023	Retire effective 12/31/2023
90875	PSYCHOPHYSIOLOGICAL THERAPY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
90876	PSYCHOPHYSIOLOGICAL THERAPY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
90882	ENVIRONMENTAL MANIPULATION	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.	_	_	_
90887	CONSULTATION WITH FAMILY	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.	_	_	_
90901	BIOFEEDBACK TRAIN ANY METH	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
90912	BFB TRAINING 1ST 15 MIN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) to avoid post-service review.	_	_	_
90999	UNLISTED DIALYSIS PROCEDURE	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
91034	Gastroesophageal Reflux Test	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) to avoid post-service review.	_	_	_
91037	Esoph Imped Function Test	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
91038	Esoph Imped Funct Test > 1Hr	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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).	_	_	_
91110	GI TRC IMG INTRAL ESOPH-ILE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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).	_	_	_
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	_	Add effective 01/01/2023
91117	Colon Motility 6 Hr Study	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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.	_	_	_
92065	ORTHOP TRAING PFRMD PHYS/QHP	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	9/30/2023	Retire effective 09/30/2023
92066	ORTHOP TRAING SUPVJ PHYS/QHP	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-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).	_	_	_
92273	Full Field Erg W/I&R	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
92274	Multifocal Erg W/I&R	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
92499	UNLISTED OPH SVC/PROCEDURE	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
92512	NASAL FUNCTION STUDIES	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, 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).	_	_	_
92546	Sinusoidal Rotational Test	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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).	_	_	_

92596	EAR PROTECTOR EVALUATION	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
92601	Cochlear Implt F/Up Exam <7	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
92602	Reprogram Cochlear Implt <7	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
92603	Cochlear Implt F/Up Exam 7/>	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
92604	REPROGRAM COCHLEAR IMPLT 7/>	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
92605	EX FOR NONSPEECH DEVICE RX	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
92606	NON-SPEECH DEVICE SERVICE	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
92607	EX FOR SPEECH DEVICE RX 1HR	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
92608	EX FOR SPEECH DEVICE RX ADDL	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
92609	USE OF SPEECH DEVICE SERVICE	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
92618	EX FOR NONSPEECH DEV RX ADD	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
92633	AUD REHAB POSTLING HEAR LOSS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
92640	Aud Brainstem Implt Programg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
92700	UNLISTED ORL SERVICE/PX	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
92974	Cath Place Cardio Brachytx	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
92978	Endoluminl Ivus Oct C 1St	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
92979	Endoluminl Ivus Oct C Ea	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
93025	Microvolt T-Wave Assess	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service 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).	_	_	_
93228	REMOTE 30 DAY ECG REV/REPORT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
93229	REMOTE 30 DAY ECG TECH SUPP	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
93260	Prgrmg Dev Eval Impltbl Sys	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
93261	Interrogate Subq Defib	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_

93264	REM MNTR WRLS P-ART PRS SNR	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
93278	Ecg/Signal-Averaged	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
93282	PRGRMG EVAL IMPLANTABLE DFB	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
93283	PRGRMG EVAL IMPLANTABLE DFB	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
93284	PRGRMG EVAL IMPLANTABLE DFB	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
93285	PRGRMG DEV EVAL SCRMS IP	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
93287	PERI-PX DEVICE EVAL & PRGR	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
93289	INTERROG DEVICE EVAL HEART	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
93290	INTERROG DEV EVAL ICPMS IP	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
93291	INTERROG DEV EVAL SCRMS IP	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
93295	DEV INTERROG REMOTE 1/2/MLT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
93296	REM INTERROG EVL PM/IDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
93297	REM INTERROG DEV EVAL ICPMS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
93298	REM INTERROG DEV EVAL SCRMS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
93356	Myocrd Strain Img Spckl Trck	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
93580	TRANSCATH CLOSURE OF ASD	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
93640	Evaluation Heart Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
93641	Electrophysiology Evaluation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
93642	Electrophysiology Evaluation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
93644	Electrophysiology Evaluation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_

93660	TILT TABLE EVALUATION	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
93668	PERIPHERAL VASCULAR REHAB	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
93701	Bioimpedance Cv Analysis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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).	_	_	_
93750	INTERROGATION VAD IN PERSON	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
93799	UNLISTED CV SVC/PROCEDURE	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
93895	CAROTID INTIMA ATHEROMA EVAL	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service 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.	_	_	_
94669	Mechanical Chest Wall Oscill	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
94799	UNLISTED PULMONARY SVC/PX	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
95027	Icut Allergy Titrate-Airborn	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service 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.	_	_	_
95249	CONT GLUC MNTR PT PROV EQP	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) to avoid post-service review.	_	_	_
95705	Eeg W/O Vid 2-12 Hr Unmntr	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) 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 (Predetermination) to avoid post-service review.	_	_	_
95708	Eeg Wo Vid Ea 12-26Hr Unmntr	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) to avoid post-service review.	_	_	_
95710	Eeg W/O Vid Ea 12-26Hr Cont	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) 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 (Predetermination) 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 (Predetermination) 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 (Predetermination) 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 (Predetermination) 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 (Predetermination) 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 (Predetermination) 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 (Predetermination) 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 (Predetermination) 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 (Predetermination) to avoid post-service review.	_	_	_
95721	Eeg Phy/Qhp>36<60 Hr W/O Vid	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) 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 (Predetermination) 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 (Predetermination) 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 (Predetermination) to avoid post-service review.	_	_	_

95726	Eeg Phy/Qhp>84 Hr W/Veeg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
95782	Polysom <6 Yrs 4/> Paramtrs	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
95783	Polysom <6 Yrs Cpap/Bilvl	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
95803	ACTIGRAPHY TESTING	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
95805	MULTIPLE SLEEP LATENCY TEST	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
95836	ECOG IMPLTD BRN NPGT <30 D	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 PUPLMTRY 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	_	Add effective 01/01/2023
95921	AUTONOMIC NRV PARASYM INERVJ	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
95922	AUTONOMIC NRV ADRENRG INERVJ	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
95923	AUTONOMIC NRV SYST FUNJ TEST	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
95924	ANS PARASYMP & SYMP W/TILT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
95925	SOMATOSENSORY TESTING	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
95926	SOMATOSENSORY TESTING	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
95927	SOMATOSENSORY TESTING	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
95930	VISUAL EP TEST CNS W/I&R	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
95938	SOMATOSENSORY TESTING	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
95940	IONM IN OPERATNG ROOM 15 MIN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	12/31/2022	Retired effective 12/31/2022
95941	IONM REMOTE/>1 PT OR PER HR	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	12/31/2022	Retired effective 12/31/2022
95954	Eeg Monitoring/Giving Drugs	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_

95957	Eeg Digital Analysis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
95961	Electrode Stimulation Brain	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
95962	Electrode Stim Brain Add-On	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
95965	MEG SPONTANEOUS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
95966	MEG EVOKED SINGLE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
95967	MEG EVOKED EACH ADDL	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
95976	Alys Smpl Cn Npgt Prgrmg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
95977	Alys Cplx Cn Npgt Prgrmg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
95980	IO ANAL GAST N-STIM INIT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
95981	IO ANAL GAST N-STIM SUBSQ	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
95982	IO GA N-STIM SUBSQ W/REPROG	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
95983	Alys Brn Npgt Prgrmg 15 Min	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	2/28/2023	Retired effective 02/28/2023
95984	Alys Brn Npgt Prgrmg Addl 15	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	2/28/2023	Retired effective 02/28/2023
95999	UNLISTED NEUROLOGICAL DX PX	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
95999	UNLISTED NEUROLOGICAL DX PX	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
96000	MOTION ANALYSIS VIDEO/3D	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) to avoid post-service review.	_	_	_
96002	DYNAMIC SURFACE EMG	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
96003	DYNAMIC FINE WIRE EMG	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) 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.	_	_	_
96570	Photodynmc Tx 30 Min Add-On	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
96571	PHOTODYNAMIC TX ADDL 15 MIN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
96912	PHOTOCHEMOTHERAPY WITH UV-A	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
96913	PHOTOCHEMOTHERAPY UV-A OR B	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
96920	LASER TX SKIN < 250 SQ CM	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
96921	LASER TX SKIN 250-500 SQ CM	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) 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 (Predetermination) 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 (Predetermination) 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 (Predetermination) 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 (Predetermination) to avoid post-service review.	_	_	_
96935	Rcm Celulr Subcelulr Img Skn	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) 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.	_	_	_
97012	Mechanical Traction Therapy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	9/30/2023	Retire effective 09/30/2023
97039	UNLISTED MODALITY	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
97139	UNLISTED THERAPEUTIC PX	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
97150	GROUP THERAPEUTIC PROCEDURES	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
97533	Sensory Integration	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
97537	Community/Work Reintegration	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
97545	Work Hardening	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
97546	Work Hardening Add-On	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_

97605	Neg Press Wound Tx <=50 Cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
97606	Neg Press Wound Tx >50 Cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
97607	Neg Press Wnd Tx <=50 Sq Cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
97608	Neg Press Wound Tx >50 Cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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.	_	_	_
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: Procedure/service 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.	_	_	_
99080	SPECIAL REPORTS OR FORMS	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
99082	UNUSUAL PHYSICIAN TRAVEL	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
99174	OCULAR INSTRUMNT SCREEN BIL	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
99177	OCULAR INSTRUMNT SCREEN BIL	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
99183	Hyperbaric Oxygen Therapy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
99199	UNLISTED SPECIAL SVC PX/RPRT	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
99429	UNLISTED PREVENTIVE SERVICE	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
99499	UNLISTED E&M SERVICE	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
99500	HOME VISIT PRENATAL	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
99506	HOME VISIT IM INJECTION	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_

99509	HOME VISIT DAY LIFE ACTIVITY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
99512	Home Visit For Hemodialysis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
99600	UNLISTED HOME VISIT SVC/PX	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
0018M	TRNSPLJ RNL MEAS CD154+CLL	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	4/30/2023	Retire effective 04/30/2023
0024U	GLYCA NUC MR SPECTRSC QUAN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0025U	TENOFOVIR LIQ CHROM UR QUAN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service 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).	_	_	_
0066U	PAMG-1 IA CERVICO-VAG FLUID	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	9/30/2023	Retire effective 09/30/2023
0067U	ONC BRST IMHCHEM PRFL 4 BMRK	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
0068U	CANDIDA SPECIES PNL AMP PRB	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	4/30/2023	Retire effective 04/30/2023
0071T	Us Leiomyomata Ablate <200	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0072T	Us Leiomyomata Ablate >200	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0075T	PERQ STENT/CHEST VERT ART	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0076T	S&I STENT/CHEST VERT ART	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
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).	_	_	_
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).	_	_	_
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	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	4/30/2023	Retire effective 04/30/2023
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).	_	_	_
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).	_	_	_
0119U	Crd Ceramides Liq Chrom Plsm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0164U	GI IBS IA ANTI-CDTB&VINCULIN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0165U	PEANUT ALLG ASMT EPI PRB ALL	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0172U	ONC SLD TUM ALYS BRCA1 BRCA2	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
0173U	PEANUT ALLG SPEC ASMT 64 EPI	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
0175U	PSYC GEN ALYS PANEL 15 GENES	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
0176U	CDTB&VINCULIN IGG ANTB IA	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0178U	PEANUT ALLG ASMT EPI CLIN RX	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0184T	Exc Rectal Tumor Endoscopic	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	9/30/2023	Retire effective 09/30/2023
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).	_	_	_
0200T	PERQ SACRAL AUGMT UNILAT INJ	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_

0201T	PERQ SACRAL AUGMT BILAT INJ	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
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).	_	_	_
0206U	NEURO ALZHEIMER CELL AGGREGJ	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	8/31/2023	Retire effective 08/31/2023
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).	_	_	_
0207U	NEURO ALZHEIMER QUAN IMAGING	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	8/31/2023	Retire effective 08/31/2023
0213T	NJX PARAVERT W/US CER/THOR	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0214T	NJX PARAVERT W/US CER/THOR	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0215T	NJX PARAVERT W/US CER/THOR	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0216T	NJX PARAVERT W/US LUMB/SAC	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0217T	NJX PARAVERT W/US LUMB/SAC	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0218T	NJX PARAVERT W/US LUMB/SAC	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
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).	_	_	_
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	_	Add effective 06/01/2023
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	_	Add effective 06/01/2023
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).	_	_	_
0253T	INSERT AQUEOUS DRAIN DEVICE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0255U	ANDROLOGY INFERTILITY ASSMT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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).	_	_	_
0263U	NEURO ASD MEAS 16 C METBLT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
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).	_	_	_
0266T	IMPLT/RPL CRTD SNS DEV TOTAL	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) 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 (Predetermination) to avoid post-service review.	_	_	_
0269T	REV/REMVL CRTD SNS DEV TOTAL	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0270T	REV/REMVL CRTD SNS DEV LEAD	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0271T	REV/REMVL CRTD SNS DEV GEN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0272T	INTERROGATE CRTD SNS DEV	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0273T	INTERROGATE CRTD SNS W/PGRMG	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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).	_	_	_
0308T	INSJ OCULAR TELESCOPE PROSTH	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0312U	AI DS SLE ALYS 8 IGG AUTOANT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0316U	B BRGDRFERI LYME DS OSPA EVL	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0322U	NEURO ASD MEAS 14 ACYL CARN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0323U	Iadna Cns Pthgn Next Gen Seq	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	4/30/2023	Retire effective 04/30/2023

0324U	Onc Ovar Sphrd Cell 4 Rx Pnl	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	3/31/2023	Retire effective 03/31/2023
0325U	Onc Ovar Sphrd Cell Parp	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	3/31/2023	Retire effective 03/31/2023
0329T	Mntr Io Press 24Hrs/> Uni/Bi	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
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).	_	_	_
0330U	IADNA VAG PTHGN PANEL 27 ORG	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	4/30/2023	Retire effective 04/30/2023
0331T	HEART SYMP IMAGE PLNR	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0332T	HEART SYMP IMAGE PLNR SPECT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0332U	ONC PAN TUM GEN PRFLG 8 DNA	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	6/30/2023	Retire effective 06/30/2023; check PA list
0333U	ONC LVR SURVEILANC HCC CFDNA	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	6/30/2023	Retire effective 06/30/2023; check PA list
0334U	ONC SLD ORGN TGSA DNA 84/+	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
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).	_	_	_
0335U	RARE DS WHL GEN SEQ FETAL	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
0336U	RARE DS WHL GEN SEQ BLD/SLV	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
0337U	ONC PLSM CELL DOandMYELOMA ID	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	6/30/2023	Retire effective 06/30/2023
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).	_	_	_
0338U	ONC SLD TUM CRCG TUM CL SLCT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
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).	_	_	_
0339U	ONC PRST8 MRNA HOXC6 and DLX1	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	6/30/2023	Retire effective 06/30/2023; check PA list

0340U	ONC PAN CA ALYS MRD PLASMA	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	6/30/2023	Retire effective 06/30/2023; check PA list
0341U	FTL ANEUP DNA SEQ CMPR ALYS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
0342T	Thxp Apheresis W/Hdl Delip	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0342U	ONC PNCRTC CA MULT IA ECLIA	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	4/30/2023	Retire effective 04/30/2023
0343U	ONC PRST8 XOM ALY 442 SNCRNA	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	6/30/2023	Retire effective 06/30/2023; check PA list
0344U	HEP NAFLD SEMIQ EVL 28 LIPID	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	6/30/2023	Retire effective 06/30/2023
0345T	TRANSCATH MTRAL VLVE REPAIR	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0345U	PSYC GENOM ALYS PNL 15 GEN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
0346U	BETA AMYL A?40andA?42 LC-MS/MS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
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).	_	_	_
0347U	RX METAB/PCX DNA 16 GEN ALYS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
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).	_	_	_
0348U	RX METAB/PCX DNA 25 GEN ALYS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
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).	_	_	_
0349U	RX METAB/PCX DNA 27GEN RX IA	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
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).	_	_	_
0350U	RX METAB/PCX DNA 27 GEN ALYS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_

0351T	Intraop Oct Brst/Node Spec	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0351U	NFCT DS BCT/VIRAL TRAIL IP10	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	6/30/2023	Retire effective 06/30/2023
0352T	OCT BRST/NODE I&R PER SPEC	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0352U	NFCT DS BVandVAGINITIS AMP PRB	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	4/30/2023	Retire effective 04/30/2023
0353T	Intraop Oct Breast Cavity	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0353U	IADNA CHLMYDandGONORR AMP PRB	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	4/30/2023	Retire effective 04/30/2023
0354T	OCT BREAST SURG CAVITY I&R	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0354U	HPV HI RSK QUAL MRNA E6/E7	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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).	_	_	_
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).	_	_	_
0398T	MRGFUS STRTCTC LES ABLTJ	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0402T	COLGN CRS-LINK CRN&PACHYMTRY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0404T	TRNSCRV UTERIN FIBROID ABLTJ	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0408T	Insj/Rplc Cardiac Modulj Sys	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0409T	Insj/Rplc Car Modulj Pls Gn	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0410T	Insj/Rplc Car Modulj Atr Elt	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0411T	Insj/Rplc Car Modulj Vnt Elt	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0412T	Rmvl Cardiac Modulj Pls Gen	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_

0413T	Rmvl Car Modulj Tranvns Elt	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0414T	Rmvl & Rpl Car Modulj Pls Gn	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0415T	Repos Car Modulj Tranvns Elt	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0416T	Reloc Skin Pocket Pls Gen	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0417T	Prgrmg Eval Cardiac Modulj	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0418T	Interro Eval Cardiac Modulj	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0421T	WATERJET PROSTATE ABLTJ CMPL	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	2/28/2023	Retired effective 02/28/2023
0422T	TACTILE BREAST IMG UNI/BI	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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).	_	_	_
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).	_	_	_
0440T	Abltj Perc Uxtr/Perph Nrv	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0441T	Abltj Perc Lxtr/Perph Nrv	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0442T	Abltj Perc Plex/Trncl Nrv	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0443T	R-T Spctrl Alys Prst8 Tiss	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0449T	INSJ AQUEOUS DRAIN DEV 1ST	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0450T	INSJ AQUEOUS DRAIN DEV EACH	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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).	_	_	_
0465T	SUPCHRDL NJX RX W/O SUPPLY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0469T	RTA POLARIZE SCAN OC SCR BI	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-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).	_	_	_
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).	_	_	_
0474T	INSJ AQUEOUS DRG DEV IO RSVR	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) 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 (Predetermination) to avoid post-service review.	_	_	_
0481T	Njx Autol Wbc Concentrate	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0483T	TMVI PERCUTANEOUS APPROACH	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0484T	TMVI TRANSTHORACIC EXPOSURE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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).	_	_	_
0494T	PREP & CANNULJ CDVR DON LUNG	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_

0495T	MNTR CDVR DON LNG 1ST 2 HRS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0496T	MNTR CDVR DON LNG EA ADDL HR	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
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).	_	_	_
0500T	HPV 5+ HI RISK HPV TYPES	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
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).	_	_	_
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).	_	_	_
0510T	Rmvl Sinus Tarsi Implant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
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).	_	_	_
0515T	Insj Wcs Lv Compl Sys	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0516T	INSJ WCS LV ELTRD ONLY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0517T	INSJ WCS LV PG COMPNT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0518T	Rmvl Pg Compnt Wcs	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0519T	Rmvl & Rplcmt Pg Compnt Wcs	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0520T	Rmvl&Rplcmt Pg Wcs New Eltrd	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0521T	Interrog Dev Eval Wcs Ip	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0522T	Prgrmg Dev Eval Wcs Ip	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0524T	EV CATH DIR CHEM ABLTJ W/IMG	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_

0525T	Insj/Rplcmt Compl Iims	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0526T	Insj/Rplcmt Iims Eltrd Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0527T	Insj/Rplcmt Iims Implt Mntr	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0528T	Prgrmg Dev Eval Iims Ip	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0529T	INTERROG DEV EVAL IIMS IP	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0530T	Removal Complete Iims	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0531T	Removal Iims Electrode Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0532T	Removal Iims Implt Mntr Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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).	_	_	_
0537T	Bld Drv T Lymphcyt Car-T Cll	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0538T	Bld Drv T Lymphcyt Prep Trns	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0539T	Receipt&Prep Car-T Cll Admn	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0540T	Car-T Cll Admn Autologous	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0544T	TCAT MV ANNULUS RCNSTJ	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0546T	RF SPECTRSC NTRAOP MRGN ASMT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0552T	LOW-LEVEL LASER THERAPY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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).	_	_	_

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).	_	_	_
0571T	INSJ/RPLCMT ICDS SS ELTRD	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0572T	INSERTION SS DFB ELECTRODE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0573T	REMOVAL SS DFB ELECTRODE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0574T	REPOS PREV SS IMPL DFB ELTRD	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0575T	PRGRMG DEV EVAL ICDS SS IP	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0576T	INTERROG DEV EVAL ICDS SS IP	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0577T	EPHYS EVAL ICDS SS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0578T	REM INTERROG DEV ICDS PHYS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0579T	REM INTERROG DEV ICDS TECH	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0580T	RMVL SS IMPL DFB PG ONLY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0581T	ABLTJ MAL BRST TUM PERQ CRTX	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0584T	PERQ ISLET CELL TRANSPLANT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0585T	LAPS ISLET CELL TRANSPLANT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0586T	OPEN ISLET CELL TRANSPLANT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) to avoid post-service review.	_	_	_
0588T	REVISION/REMOVAL ISDNS PTN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) to avoid post-service review.	_	_	_
0590T	ELEC ALYS CPLX PRGRMG IINS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0591T	HLTH&WB COACHING INDIV 1ST	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_

0592T	HLTH&WB COACHING INDIV F-UP	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
0593T	HLTH&WB COACHING GROUP	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
0594T	OSTEOT HUM XTRNL LNGTH DEV	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	10/31/2023	Retire effective 10/31/2023
0596T	TEMP FML IU VLV-PMP 1ST INSJ	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0597T	TEMP FML IU VALVE-PMP RPLCMT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0598T	NCNTC R-T FLUOR WND IMG 1ST	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0599T	NCNTC R-T FLUOR WND IMG EA	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0600T	IRE ABLTJ 1+TUM ORGAN PERQ	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0601T	IRE ABLTJ 1+TUMORS OPEN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
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).	_	_	_
0604T	REM OCT RTA DEV SETUP&EDUCAJ	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0605T	REM OCT RTA TECHL SPRT MIN 8	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0606T	REM OCT RTA PHYS/QHP EA 30D	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0607T	REM MNTR PULM FLU MNTR SETUP	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0608T	REM MNTR PULM FLU MNTR ALYS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0613T	PERQ TCAT INTRATRL SEPTL SHT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0614T	RMVL&RPLCMT SS IMPL DFB PG	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
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).	_	_	_
0616T	INSERTION OF IRIS PROSTHESIS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0617T	INSJ IRIS PROSTH W/RMVL&INSJ	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_

0618T	INSJ IRIS PROSTH SEC IO LENS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0619T	CYSTO W/PRST8 COMMISSUROTOMY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
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).	_	_	_
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).	_	_	_
0632T	PERQ TCAT US ABLTJ NRV P-ART	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	4/30/2023	Retire effective 06/30/2023
0632T	PERQ TCAT US ABLTJ NRV P-ART	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	7/1/2023	4/30/2023	Add effective 07/01/2023
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).	_	_	_

0643T	TCAT L VENTR RSTRJ DEV IMPLT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) 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 (Predetermination) to avoid post-service review.	_	_	_
0647T	INSJ GTUBE PERQ MAG GASTRPXY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	4/30/2023	Retire effective 04/30/2023
0650T	PRGRMG DEV EVAL SCRMS REMOTE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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	_	Add effective 01/01/2023
0655T	TPRNL FOCAL ABLTJ MAL PRST8	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
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).	_	_	_
0658T	Elec Impd Spectrsc 1+Skn Les	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0659T	TCAT INTRA-C NFS SUPERSAT O2	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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).	_	_	_
0671T	INSJ ANT SGM AQ DRG DEV 1+	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
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).	_	_	_

0673T	ABLTJ B9 THYR NDUL PERQ LASR	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0686T	HISTOTRIPSY MAL HEPATCEL TIS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0687T	TX AMBLYOPIA DEV SETUP 1ST	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0688T	TX AMBLYOPIA ASSMT W/REPORT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0692T	THERAPEUTIC ULTRAFILTRATION	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0693T	COMPRE FUL BDY 3D MTN ALYS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0697T	QUAN MR TIS WO MRI MLT ORGN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	4/30/2023	Retire effective 04/30/2023
0700T	MOLEC FLUOR IMG SUS NEV 1ST	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0701T	MOLEC FLUOR IMG SUS NEV EA	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0707T	NJX B1 SUB MTRL SBCHDRL DFCT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0708T	ID CA IMMNTX PREP & 1ST NJX	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	4/30/2023	Retire effective 04/30/2023
0710T	N-INVAS ARTL PLAQ ALYS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0711T	N-NVS ARTL PLAQ ALYS DAT PRP	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0712T	N-NVS ARTL PLAQ ALYS QUAN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0713T	N-NVS ARTL PLAQ ALYS RVW I&R	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0714T	Tprnl Lsr Ablt B9 Prst8 Hypr	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0715T	Perq Trluml Coronry Lithotrp	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0716T	Car Acous Wavfrm Rec Cad Rsk	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	6/30/2023	Retire effective 06/30/2023
0717T	Adrc Ther Prtl Rc Tear	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	4/30/2023	Retire effective 04/30/2023
0718T	Adrc Ther Prtl Rc Tear Njx	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	4/30/2023	Retire effective 04/30/2023

0719T	Pst Vrt Jt Rplcmt Lmbr 1 Sgm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0720T	Prq Elc Nrv Stim Cn Wo Implt	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0721T	Quan Ct Tiss Charac W/O Ct	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	4/30/2023	Retire effective 04/30/2023
0722T	Quan Ct Tiss Charac W/Ct	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	4/30/2023	Retire effective 04/30/2023
0723T	Qmrcp W/O Dx Mri Sm Anat Ses	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	4/30/2023	Retire effective 04/30/2023
0724T	Qmrcp W/Dx Mri Same Anatomy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	4/30/2023	Retire effective 04/30/2023
0725T	Vestibular Dev Impltj Uni	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	4/30/2023	Retire effective 04/30/2023
0726T	Rmvl Implt Vstibular Dev Uni	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	4/30/2023	Retire effective 04/30/2023
0727T	Rmvlandrplcmt Implt Vstblr Dev	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	4/30/2023	Retire effective 04/30/2023
0728T	Dx Alys Vstblr Implt Uni 1St	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	4/30/2023	Retire effective 04/30/2023
0729T	Dx Alys Vstblr Implt Uni Sbq	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	4/30/2023	Retire effective 04/30/2023
0730T	Trabeculotomy Lsr W/Oct Gdn	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	4/30/2023	Retire effective 04/30/2023
0731T	Augmnt Ai-Based Fcl Phnt A/R	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	4/30/2023	Retire effective 04/30/2023
0732T	Immntx Admn Electroporatn Im	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	4/30/2023	Retire effective 04/30/2023
0733T	Rem Bdyandlmb Knmtc Ther Sply	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0734T	Rem Bdyandlmb Knmtc Tx Mgmt	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0735T	Prep Tum Cav Iort Prim Crnot	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	4/30/2023	Retire effective 04/30/2023
0737T	Xenograft Impltj Artclr Surf	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
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	_	Add effective 01/01/2023
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	_	Add effective 09/01/2023

0744T	Insj Bioprostc Vlv Fem Vn	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	6/1/2023	8/31/2023	Add effective 06/01/2023; Retire effective 08/31/2023
0745T	Car Ablt Rad Arr N-Invas Loc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	6/15/2023	–	Add effective 06/15/2023
0746T	Car Ablt Rad Arr Cnv Loc Map	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	6/15/2023	–	Add effective 06/15/2023
0747T	Car Ablt Rad Arrhyt Dlvr Rad	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	6/15/2023	–	Add effective 06/15/2023
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	–	Add effective 09/01/2023
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	–	Add effective 09/01/2023
0748T	Njx Stm Cl Prdct Anl Sft Tis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	6/15/2023	8/31/2023	Add effective 06/15/2023; Retire effective 08/31/2023
0764T	Asstv Alg Ecg Rsk Asmt Cncrt	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	6/15/2023	–	Add effective 06/15/2023
0765T	Asstv Alg Ecg Rsk Asmt Prev	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	6/15/2023	–	Add effective 06/15/2023
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	–	Add effective 07/01/2023
0766T	Tc Mag Stimj Pn 1St Tx 1Nrv	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	6/15/2023	6/30/2023	Add effective 06/15/2023 and retire effective 06/30/2023
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	–	Add effective 07/01/2023
0767T	Tc Mag Stimj Pn 1St Tx Ea	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	6/15/2023	6/30/2023	Add effective 06/15/2023 and retire effective 06/30/2023
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	–	Add effective 07/01/2023
0768T	Tc Mag Stimj Pn Sbsq Tx 1Nrv	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	6/15/2023	6/30/2023	Add effective 06/15/2023 and retire effective 06/30/2023
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	–	Add effective 07/01/2023

0769T	Tc Mag Stimj Pn Sbsq Tx Ea	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	6/15/2023	6/30/2023	Add effective 06/15/2023 and retire effective 06/30/2023
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	–	Add effective 09/01/2023
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	–	Add effective 09/01/2023
0770T	Vr Technology Assist Therapy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	6/15/2023	8/31/2023	Add effective 06/15/2023; Retire effective 08/31/2023
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	–	Add effective 09/01/2023
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	–	Add effective 09/01/2023
0771T	Vr Px Dissoc Svc Sm Phy 1St	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	6/15/2023	8/31/2023	Add effective 06/15/2023; Retire effective 08/31/2023
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	–	Add effective 09/01/2023
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	–	Add effective 09/01/2023
0772T	Vr Px Dissoc Svc Sm Phy Ea	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	6/15/2023	8/31/2023	Add effective 06/15/2023; Retire effective 08/31/2023
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	–	Add effective 09/01/2023
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	–	Add effective 09/01/2023
0773T	Vr Px Dissoc Svc Oth Phy 1St	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	6/15/2023	8/31/2023	Add effective 06/15/2023; Retire effective 08/31/2023
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	–	Add effective 09/01/2023
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	–	Add effective 09/01/2023
0774T	Vr Px Dissoc Svc Oth Phy Ea	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	6/15/2023	8/31/2023	Add effective 06/15/2023; Retire effective 08/31/2023

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	–	Add effective 01/01/2023
0776T	Ther Indctj Ntrabrn Hypthrm	EIU: Procedure/service not 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	–	Add effective 09/01/2023
0776T	Ther Indctj Ntrabrn Hypthrm	EIU: Procedure/service not 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	–	Add effective 09/01/2023
0776T	Ther Indctj Ntrabrn Hypthrm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	6/15/2023	8/31/2023	Add effective 06/15/2023; Retire effective 08/31/2023
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	–	Add effective 09/01/2023
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	–	Add effective 09/01/2023
0777T	R-T Prs Sensing Edrl Gdn Sys	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	6/15/2023	8/31/2023	Add effective 06/15/2023; Retire effective 08/31/2023
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	–	Add effective 09/01/2023
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	–	Add effective 09/01/2023
0778T	Smmg Cncrnt Appl Imu Snr	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	6/15/2023	8/31/2023	Add effective 06/15/2023; Retire effective 08/31/2023
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	–	Add effective 09/01/2023
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	–	Add effective 09/01/2023
0779T	Gi Myoelectrical Actv Study	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	6/15/2023	8/31/2023	Add effective 06/15/2023; Retire effective 08/31/2023
0780T	INSTLJ FECAL MICROBIOTA SSP	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2023	–	Add effective 01/01/2023
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	–	Add effective 09/01/2023
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	–	Add effective 09/01/2023
0781T	Brnchsc Rf Dstrj Pulm Nrv Bi	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	6/15/2023	8/31/2023	Add effective 06/15/2023; Retire effective 08/31/2023

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	–	Add effective 09/01/2023
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	–	Add effective 09/01/2023
0782T	Brnchsc Rf Dstrj Plm Nrv Uni	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	6/15/2023	8/31/2023	Add effective 06/15/2023; Retire effective 08/31/2023
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	–	Add effective 01/01/2023
0791T	MOTR COG VR GAIT TRAIN EA 15	EIU: Procedure/service not 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	–	Add effective 07/01/2023
0793T	PRQ TCAT THRM ABLT NRV P-ART	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	7/1/2023	–	Add effective 07/01/2023
0795T	TCAT INS 2CHMBR LDLS PM CMPL	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	7/1/2023	–	Add effective 07/01/2023
0796T	TCAT INS 2CHMBR LDLS PM RA	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	7/1/2023	–	Add effective 07/01/2023
0797T	TCAT INS 2CHMBR LDLS PM RV	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	7/1/2023	–	Add effective 07/01/2023
0798T	TCAT RMV 2CHMBR LDLS PM CMPL	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	7/1/2023	–	Add effective 07/01/2023
0799T	TCAT RMVL 2CHMBR LDLS PM RA	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	7/1/2023	–	Add effective 07/01/2023
0800T	TCAT RMVL 2CHMBR LDLS PM RV	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	7/1/2023	–	Add effective 07/01/2023
0801T	TCAT RMV&RPL 2CHMBR LDLS PM	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	7/1/2023	–	Add effective 07/01/2023
0802T	TCAT RMV&RPL2CHMB LDLS PM RA	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	7/1/2023	–	Add effective 07/01/2023
0803T	TCAT RMV&RPL2CHMB LDLS PM RV	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	7/1/2023	–	Add effective 07/01/2023
0804T	PRGRMG EVL LDLS PM 2CHMBR IP	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	7/1/2023	–	Add effective 07/01/2023
0805T	TCAT S&IVC PRSTC VL IMPL PRQ	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	7/1/2023	–	Add effective 07/01/2023
0806T	TCAT S&IVC PRSTC VL IMPL OPN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	7/1/2023	–	Add effective 07/01/2023
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	–	Add effective 07/01/2023
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	–	Add effective 07/01/2023

0810T	SUBRTA NJX RX AGT W/VTRC	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	7/1/2023	_	Add effective 07/01/2023
3051F	HG A1C>EQUAL 7.0%<8.0%	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
3052F	HG A1C>EQUAL 8.0%<EQUAL 9.0%	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
9001F	AORTIC ANEURYSM<5CM DIAM CT	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
9002F	AORTIC ANEURYSM 5-5.4CM DIAM	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
9003F	AORTIC ANRYSM5.5-5.9CM DIAM	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
9004F	AORTIC ANRYSM 6/> CM DIAM	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
9005F	ASYMPT CAROT/VRTBRBAS STEN	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
9006F	SYMPT STEN-TIA/STRK<120DAYS	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
9007F	OTHER CAROT STEN 120 DAYS/>	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
A0021	Outside state ambulance serv	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
A0080	Noninterest escort in non er	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
A0090	Interest escort in non er	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
A0100	Nonemergency transport taxi	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
A0110	Nonemergency transport bus	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
A0120	Noner transport mini-bus	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
A0130	Noner transport wheelch van	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
A0140	Nonemergency transport air	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
A0160	Noner transport case worker	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
A0170	Transport parking fees/tolls	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
A0180	Noner transport lodgng recip	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
A0190	Noner transport meals recip	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
A0200	Noner transport lodgng escrt	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
A0210	Noner transport meals escort	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
A0225	Ambulance service neonatal transport base rate emergency transport one way	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
A0380	Bls mileage (per mile)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
A0390	Als mileage (per mile)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
A0420	Ambulance Waiting Time (Als Or Bls) One Half (1/2) Hour Increments	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_

A0424	Extra ambulance attendant ground (als or bls) or air (fixed or rotary winged); (requires medical review)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
A0425	Ground mileage per statute mile	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
A0426	Als 1	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
A0427	Ambulance Service Advanced Life Support Emergency Transport Level 1 (Als1-Emergency)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
A0428	Ambulance Service Basic Life Support Non-Emergency Transport (Bls)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
A0429	Ambulance service basic life support emergency transport (bls-emergency)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
A0432	Paramedic Intercept (Pi) Rural Area Transport Furnished By A Volunteer Ambulance Company Which Is Prohibited By State Law From Billing Third Party Payers	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
A0433	Advanced life support level 2 (als 2)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
A0434	Specialty care transport (sct)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
A0888	Noncovered ambulance mileage	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
A0998	Ambulance Response And Treatment No Transport	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
A0999	Unlisted ambulance service	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
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).	_	_	_
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	_	Add effective 04/01/2023
A2014	Omeza collag per 100 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	3/31/2023	Retire effective 03/31/2023
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	_	Add effective 04/01/2023
A2015	Phoenix wnd mtrx per sq cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	3/31/2023	Retire effective 03/31/2023
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	_	Add effective 04/01/2023
A2016	Permeaderm b per sq cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	3/31/2023	Retire effective 03/31/2023
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	_	Add effective 04/01/2023
A2017	Permeaderm glove each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	3/31/2023	Retire effective 03/31/2023
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	_	Add effective 04/01/2023
A2018	Permeaderm c per sq cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	3/31/2023	Retire effective 03/31/2023
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	_	Add effective 09/01/2023
A2020	Ac5 Wound System	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	6/1/2023	8/31/2023	Add effective 06/01/2023; Retire effective 08/31/2023
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	_	Add effective 09/01/2023

A2021	Neomatrix Per Sq Cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	6/1/2023	8/31/2023	Add effective 06/01/2023; Retire effective 08/31/2023
A4100	Skin sub fda clrd as dev nos	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
A4226	Supplies for maintenance of insulin infusion pump with dosage rate adjustment using therapeutic continuous glucose sensing per week	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
A4244	Alcohol or peroxide per pint	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
A4245	Alcohol wipes per box	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
A4246	Betadine/phisohex solution	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
A4247	Betadine/iodine swabs/wipes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
A4290	Sacral nerve stimulation test lead each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
A4335	Incontinence supply	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
A4337	Incontinence supply rectal insert any type each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
A4421	Ostomy supply misc	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
A4450	Non-waterproof tape	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
A4452	Waterproof tape	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
A4453	Rec cath man pump enema repl	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
A4458	Reusable enema bag	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
A4459	Manual pump-operated enema system includes balloon catheter and all accessories reusable any type	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
A4490	Above knee surgical stocking	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
A4495	Thigh length surg stocking	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
A4500	Below knee surgical stocking	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
A4510	Full length surg stocking	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.	_	_	_
A4555	Ca tx e-stim electr/transduc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_

A4556	Electrodes (e. G. apnea monitor) per pair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
A4557	Lead wires (e. G. apnea monitor) per pair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-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).	_	_	_
A4595	Electrical Stimulator Supplies 2 Lead Per Month (E. G. Tens Nmes)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
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	_	Add effective 04/01/2023
A4596	Ces system monthly supp	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	3/31/2023	Retire effective 03/31/2023
A4600	Sleeve inter limb comp dev	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
A4606	Oxygen probe for use with oximeter device replacement	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
A4630	Replacement Batteries Medically Necessary Transcutaneous Electrical Stimulator Owned By Patient	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
A4638	Replacement Battery For Patient-Owned Ear Pulse Generator Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
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.	_	_	_
A4660	Sphygmomanometer/Blood Pressure Apparatus With Cuff And Stethoscope	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
A4663	Blood Pressure Cuff Only	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
A4870	Plumbing and/or electrical work for home hemodialysis equipment	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
A4913	Misc dialysis supplies noc	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
A4927	Non-sterile gloves	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
A4928	Surgical mask per 20	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
A4930	Gloves Sterile Per Pair	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.	_	_	_
A6550	Neg pres wound ther drsg set	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
A7020	Interface For Cough Stimulating Device Includes All Components Replacement Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
A7025	High Frequency Chest Wall Oscillation System Vest Replacement For Use With Patient Owned Equipment Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
A7026	High Frequency Chest Wall Oscillation System Hose Replacement For Use With Patient Owned Equipment Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
A8000	HELMET PROTECTIVE SOFT PREFABRICATED INCLUDES ALL COMPONENTS AND ACCESSORIES	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
A8001	HELMET PROTECTIVE HARD PREFABRICATED INCLUDES ALL COMPONENTS AND ACCESSORIES	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
A8002	HELMET PROTECTIVE SOFT CUSTOM FABRICATED INCLUDES ALL COMPONENTS AND ACCESSORIES	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
A8003	HELMET PROTECTIVE HARD CUSTOM FABRICATED INCLUDES ALL COMPONENTS AND ACCESSORIES	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
A8004	SOFT INTERFACE FOR HELMET REPLACEMENT ONLY	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
A9150	Misc/exper non-prescript dru	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
A9152	Single vitamin nos	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
A9153	Multi-vitamin nos	Unlisted: Procedure/service 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.	_	_	_
A9272	Wound Suction Disposable Includes Dressing All Accessories And Components Any Type Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
A9273	Hot/cold botle/cap/col/wrap	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_

A9274	External Ambulatory Insulin Delivery System Disposable Each Includes All Supplies And Accessories	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	9/30/2023	Retire effective 09/30/2023
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.	_	_	_
A9281	Reaching/Grabbing Device Any Type Any Length Each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service 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).	_	_	_
A9286	Hygienic item or device disposable or non-disposable any type each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
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.	_	_	_
A9515	Choline C-11 Diagnostic Per Study Dose Up To 20 Millicuries	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
A9526	NITROGEN N-13 AMMONIA DIAGNOSTIC PER STUDY DOSE UP TO 40 MILLICURIES	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
A9552	FLUORODEOXYGLUCOSE F-18 FDG DIAGNOSTIC PER STUDY DOSE UP TO 45 MILLICURIES	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
A9555	RUBIDIUM RB-82 DIAGNOSTIC PER STUDY DOSE UP TO 60 MILLICURIES	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
A9579	Gad-base MR contrast NOS 1ml	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
A9580	Sodium Fluoride F-18 Diagnostic Per Study Dose Up To 30 Millicuries	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
A9582	Iodine I-123 Iobenguane Diagnostic Per Study Dose Up To 15 Millicuries	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
A9586	Florbetapir f18 diagnostic per study dose up to 10 millicuries	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
A9587	Gallium ga-68 dotatate diagnostic 0.1 millicurie	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
A9588	Fluciclovine F-18 Diagnostic 1 Millicurie	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
A9591	Fluoroestradiol f 18 diagnostic 1 millicurie	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
A9592	Copper cu-64 dotatate diagnostic 1 millicurie	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
A9593	Gallium ga-68 psma-11 diagnostic (ucsf) 1 millicurie	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_

A9594	Gallium ga-68 psma-11 diagnostic (ucla) 1 millicurie	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
A9595	Piflufolastat f-18 diagnostic 1 millicurie	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
A9596	Gallium Illuccix 1 Millicure	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
A9597	Pet dx for tumor id noc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service 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	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
A9598	Pet dx for non-tumor id noc	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
A9601	Flortaucipir Inj 1 Millicuri	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
A9602	Fluorodopa f-18 diag per mci	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
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.	_	_	_
A9800	Gallium locametz 1 millicuri	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
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.	_	_	_
B4100	Food thickener administered orally per ounce	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
B4102	EF adult fluids and electro	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
B4103	EF ped fluid and electrolyte	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
B4104	Additive for enteral formula	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
B4105	Enzyme cartridge enteral nut	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
B4149	EF blenderized foods	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
B4150	EF complet w/intact nutrient	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
B4152	EF calorie dense>/=1.5Kcal	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_

B4153	Enteral Formula Nutritionally Complete Hydrolyzed Proteins (Amino Acids And Peptide Chain) Includes Fats Carbohydrates Vitamins And Minerals May Include Fiber Administered Through An Enteral Feeding Tube 100 Calories = 1 Unit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
B4154	EF spec metabolic noninherit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
B4155	Enteral Formula Nutritionally Incomplete/Modular Nutrients Includes Specific Nutrients Carbohydrates (E. G. Glucose Polymers) Proteins/Amino Acids (E. G. Glutamine Arginine) Fat (E. G. Medium Chain Triglycerides) Or Combination Administered Through An Enteral Feeding Tube 100 Calories = 1 Unit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
B4158	EF ped complete intact nut	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
B4159	EF ped complete soy based	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
B4160	EF ped caloric dense>/=0.7kc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
B4161	Enteral Formula For Pediatrics Hydrolyzed/Amino Acids And Peptide Chain Proteins Includes Fats Carbohydrates Vitamins And Minerals May Include Fiber Administered Through An Enteral Feeding Tube 100 Calories = 1 Unit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
B4164	Parenteral 50% dextrose solu	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
B4168	Parenteral Nutrition Solution; Amino Acid 3. 5% (500 Ml = 1 Unit) - Homemix	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
B4172	Parenteral Nutrition Solution; Amino Acid 5. 5% Through 7% (500 Ml = 1 Unit) - Homemix	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
B4176	Parenteral Nutrition Solution; Amino Acid 7% Through 8. 5% (500 Ml = 1 Unit) - Homemix	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
B4178	Parenteral Nutrition Solution: Amino Acid Greater Than 8. 5% (500 Ml = 1 Unit) - Homemix	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_

B4180	Parenteral Nutrition Solution; Carbohydrates (Dextrose) Greater Than 50% (500 Ml=1 Unit) - Homemix	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
B4185	Parenteral Nutrition Solution Not Otherwise Specified 10 Grams Lipids	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
B4187	Omegaven 10 grams lipids	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
B4189	Parenteral nutrition solution; compounded amino acid and carbohydrates with electrolytes trace elements and vitamins including preparation any strength 10 to 51 grams of protein - premix	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
B4193	Parenteral Nutrition Solution; Compounded Amino Acid And Carbohydrates With Electrolytes Trace Elements And Vitamins Including Preparation Any Strength 52 To 73 Grams Of Protein - Premix	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
B4197	Parenteral Nutrition Solution; Compounded Amino Acid And Carbohydrates With Electrolytes Trace Elements And Vitamins Including Preparation Any Strength 74 To 100 Grams Of Protein - Premix	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
B4199	Parenteral Nutrition Solution; Compounded Amino Acid And Carbohydrates With Electrolytes Trace Elements And Vitamins Including Preparation Any Strength Over 100 Grams Of Protein - Premix	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
B4216	Parenteral Nutrition; Additives (Vitamins Trace Elements Heparin Electrolytes) Homemix Per Day	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
B4220	Parenteral Nutrition Supply Kit; Premix Per Day	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
B4222	Parenteral Nutrition Supply Kit; Home Mix Per Day	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
B4224	Parenteral Nutrition Administration Kit Per Day	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_

B5000	Parenteral Nutrition Solution Compounded Amino Acid And Carbohydrates With Electrolytes Trace Elements And Vitamins Including Preparation Any Strength Renal-Aminosyn-Rf Nephramine Renamine-Premix	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
B5100	Parenteral Nutrition Solution Compounded Amino Acid And Carbohydrates With Electrolytes Trace Elements And Vitamins Including Preparation Any Strength Hepatic Hepatamine-Premix	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
B5200	Parenteral Nutrition Solution Compounded Amino Acid And Carbohydrates With Electrolytes Trace Elements And Vitamins Including Preparation Any Strength Stress-Branch Chain Amino Acids-Freamine-Hbc-Premix	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
B9002	Enteral nutrition infusion pump any type	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
B9004	Parenteral Nutrition Infusion Pump Portable	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
B9006	Parenteral Nutrition Infusion Pump Stationary	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
B9998	Enteral supp not otherwise c	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
B9999	Parenteral supp not othrws c	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
C1052	Hemostatic agent gi topic	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
C1062	Intravertebral body fracture augmentation with implant (e.g., metal, polymer)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
C1717	brachytherapy source high dose rate "NON-STRANDED"	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
C1721	AICD dual chamber	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
C1722	AICD single chamber	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
C1726	Cath Bal Dil Non-Vascular	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	6/30/2023	Retire effective 06/30/2023
C1734	Orthopedic/device/drug matrix for opposing bone-to-bone or soft tissue-to bone (implantable)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
C1761	Cath trans intra litho/coro	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_

C1764	Event recorder cardiac	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
C1767	Generator neuro non-recharg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
C1776	Joint device (implantable)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
C1778	Lead Neurostimulator	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
C1783	Ocular imp aqueous drain de	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
C1787	Patient Progr Neurostim	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
C1816	Receiver/Transmitter Neuro	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
C1817	Septal defect imp sys	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
C1818	Integrated keratoprosthesis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
C1820	Generator Neurostimulator (Implantable) With Rechargeable Battery And Charging System	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
C1821	Interspinous Process Distraction Device (Implantable)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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).	_	_	_
C1824	Generator cardiac contractility modulation (implantable)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) 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 (Predetermination) to avoid post-service review.	7/1/2023	_	Add effective 07/01/2023
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	_	Add effective 09/01/2023
C1827	Gen Neuro Imp Led Ex Cntr	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	5/1/2023	8/31/2023	Add effective 05/01/2023; Retire effective 08/31/2023
C1831	Personalized Interbody Cage	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
C1833	Cardiac monitor sys	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_

C1840	Lens intraocular (telescopic)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
C1882	AICD other than sing/dual	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
C1883	Adapt/Ext Pacing/Neuro Lead	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
C1889	Implant/insert device noc	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
C1895	Lead AICD endo dual coil	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
C1896	Lead AICD non sing/dual	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
C1897	Lead neurostim test kit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
C1899	Lead pmkr/AICD combination	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
C1982	Catheter pressure-generating one-way valve intermittently occlusive	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
C2596	Probe image-guided robotic waterjet ablation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
C2614	Probe Percutaneous Lumbar Discectomy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
C2616	Brachytx Source Yttrium-90 "Non-Stranded"	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
C2623	Cath translumin drug-coat	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
C2624	Wireless pressure sensor	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
C2634	BRACHYTHERAPY SOURCE HIGH ACTIVITY IODINE-125 PER SOURCE "NON-STRANDED"	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
C2635	BRACHYTHERAPY SOURCE HIGH ACTIVITY PALADIUM-103 PER SOURCE "NON-STRANDED"	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
C2636	BRACHYTHERAPY LINEAR SOURCE PALADIUM-103 PER 1 MM "NON-STRANDED"	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
C2637	BRACHYTHERAPY SOURCE YTTERBIUM-169 PER SOURCE "NON-STRANDED"	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
C2638	BRACHYTHERAPY SOURCE STRANDED IODINE-125 PER SOURCE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
C2639	BRACHYTHERAPY SOURCE NON-STRANDED IODINE-125 PER SOURCE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_

C2640	BRACHYTHERAPY SOURCE STRANDED PALLADIUM-103 PER SOURCE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
C2641	BRACHYTHERAPY SOURCE NON-STRANDED PALLADIUM-103 PER SOURCE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
C2642	BRACHYTHERAPY SOURCE STRANDED CESIUM-131 PER SOURCE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
C2643	BRACHYTHERAPY SOURCE NON-STRANDED CESIUM-131 PER SOURCE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
C2644	Brachytherapy source cesium-131 chloride solution per millicurie	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
C2645	Brachytherapy planar source palladium-103 per square millimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
C2698	Brachytx stranded NOS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
C2698	Brachytx stranded NOS	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
C2699	Brachytx non-stranded NOS	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
C5271	Low cost skin substitute app	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	4/1/2023	_	Add effective 04/01/2023
C5272	Low cost skin substitute app	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	4/1/2023	_	Add effective 04/01/2023
C5273	Low cost skin substitute app	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	4/1/2023	_	Add effective 04/01/2023
C5274	Low cost skin substitute app	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	4/1/2023	_	Add effective 04/01/2023
C5275	Low cost skin substitute app	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	4/1/2023	_	Add effective 04/01/2023
C5276	Low cost skin substitute app	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	4/1/2023	_	Add effective 04/01/2023
C5277	Low cost skin substitute app	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	4/1/2023	_	Add effective 04/01/2023
C5278	Low cost skin substitute app	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	4/1/2023	_	Add effective 04/01/2023
C9047	Injection caplacizumab-yhdp 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
C9067	Gallium ga-68 dotatoc diagnostic 0.01 mci	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
C9149	Inj, Teplizumab-Mzwv, 5 Mcg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	6/1/2023	6/30/2023	Add effective 06/01/2023 Retire effective 06/30/2023

C9257	Bevacizumab injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	6/30/2023	Retire effective 06/30/2023
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).	_	_	_
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).	_	_	_
C9359	Porous purified collagen matrix bone void filler (Integra Mozaik Osteoconductive Scaffold Putty Integra OS Osteoconductive Scaffold Putty) per 0.5 cc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
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).	_	_	_
C9362	Porous purified collagen matrix bone void filler (Integra Mozaik Osteoconductive Scaffold Strip) per 0.5 cc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
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; May require Prior Authorization per contract agreement.	_	_	_
C9726	Placement and removal (if performed) of applicator into breast for radiation therapy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
C9727	Insertion of implants into the soft palate; minimum of three implants	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
C9734	U/S trtmt not leiomyomata	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
C9739	Cystoscopy prostatic imp 1-3	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
C9740	Cysto impl 4 or more	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_

C9751	Bronchoscopy rigid or flexible transbronchial ablation of lesion(s) by microwave energy including fluoroscopic guidance when performed with computed tomography acquisition(s) and 3-d rendering computer-assisted image-guided navigation and endobronchial ultrasound (ebus) guided transtracheal and/or transbronchial sampling (eg aspiration[s]/biopsy[ies]) and all mediastinal and/or hilar lymph node stations or structures and therapeutic intervention(s)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
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).	_	_	_
C9760	Non-randomized non-blinded procedure for nyha class ii iii iv heart failure; transcatheter implantation of interatrial shunt including right and left heart catheterization transeptal puncture trans-esophageal echocardiography (tee)/intracardiac echocardiography (ice) and all imaging with or without guidance (e.g. ultrasound fluoroscopy) performed in an approved investigational device exemption (ide) study	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
C9762	Cardiac magnetic resonance imaging for morphology and function quantification of segmental dysfunction; with strain imaging	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
C9764	Revasc intravasc lithotripsy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
C9765	Revasc intra lithotrip-stent	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
C9766	Revasc intra lithotrip-ather	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
C9767	Revasc lithotrip-stent-ather	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
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).	_	_	_
C9769	Cysto w/temp pros implant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_

C9770	Vitrec/mech pars subret inj	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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).	_	_	_
C9778	Colpopexy vaginal; minimally invasive extra-peritoneal approach (sacrospinous)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
C9782	Blinded procedure for new york heart association (nyha) class ii or iii heart failure or canadian cardiovascular society (ccs) class iii or iv chronic refractory angina; transcatheter intramyocardial transplantation of autologous bone marrow cells (e.g. mononuclear) or placebo control autologous bone marrow harvesting and preparation for transplantation left heart catheterization including ventriculography all laboratory services and all imaging with or without guidance (e.g. transthoracic echocardiography ultrasound fluoroscopy) performed in an approved investigational device exemption (ide) study	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_

C9783	Blinded procedure for transcatheter implantation of coronary sinus reduction device or placebo control including vascular access and closure right heart catherization venous and coronary sinus angiography imaging guidance and supervision and interpretation when performed in an approved investigational device exemption (ide) study	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
C9898	Inpnt stay radiolabeled item	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
C9899	Inpt implant pros dev no cov	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
E0170	COMMODE CHAIR WITH INTEGRATED SEAT LIFT MECHANISM ELECTRIC ANY TYPE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	–	–	–
E0172	SEAT LIFT MECHANISM PLACED OVER OR ON TOP OF TOILET ANY TYPE	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
E0183	Press underlay alter w/pump	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	–	–	–
E0190	Positioning cushion	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
E0210	Electric heat pad standard	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
E0215	Electric heat pad moist	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).	–	–	–
E0225	Hydrocollator Unit Includes Pads	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
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.	–	–	–
E0239	Hydrocollator Unit Portable	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.	–	–	–
E0249	Pad water circulating heat u	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

E0270	Hospital Bed Institutional Type Includes: Oscillating Circulating And Stryker Frame With Mattress	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E0273	Bed board	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
E0274	Over-bed table	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
E0300	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 (Predetermination) to avoid post-service review.	_	_	_
E0315	Bed accessory brd/tbl/supprt	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
E0316	Bed safety enclosure	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E0328	Hospital Bed Pediatric Manual 360 Degree Side Enclosures Top Of Headboard	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E0329	Hospital Bed Pediatric Electric Or Semi-Electric 360 Degree Side Enclosures	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E0350	Control unit for electronic bowel irrigation/evacuation system	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E0352	Disposable pack (water reservoir bag speculum valving mechanism and collection bag/box) for use with the electronic bowel irrigation/evacuation system	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E0445	Oximeter device for measuring blood oxygen levels non-invasively	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
E0446	Topical Ox Deliver sys nos	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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.	_	_	_
E0470	Respiratory assist device bi-level pressure capability without backup rate feature used with noninvasive interface e. G. nasal or facial mask (intermittent assist device with continuous positive airway pressure device)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	9/30/2023	Retire effective 09/30/2023
E0471	RAD w/backup non inv intrfc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	9/30/2023	Retire effective 09/30/2023
E0481	Intrapulmonary Percussive Ventilation System And Related Accessories	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E0482	Cough Stimulating Device Alternating Positive And Negative Airway Pressure	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E0483	High Frequency Chest Wall Oscillation System Includes All Accessories And Supplies Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_

E0484	Oscillatory Positive Expiratory Pressure Device Non-Electric Any Type Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E0485	Oral device/appliance prefab	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E0486	Oral device/appliance cusfab	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
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).	_	_	_
E0616	Cardiac event recorder	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E0617	Automatic ext defibrillator	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E0618	Apnea Monitor Without Recording Feature	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E0619	Apnea Monitor With Recording Feature	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E0621	Sling or seat patient lift canvas or nylon	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E0625	Patient lift bathroom or toi	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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.	_	_	_
E0627	Seat Lift Mechanism Electric Any Type	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E0629	Seat Lift Mechanism Non-Electric Any Type	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E0630	Patient lift hydraulic or mechanical includes any seat sling strap(s) or pad(s)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E0635	Patient Lift Electric With Seat Or Sling	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
E0636	Multipositional Patient Support System With Integrated Lift Patient Accessible Controls	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) 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 (Predetermination) to avoid post-service review.	_	_	_

E0639	Patient Lift Moveable From Room To Room With Disassembly And Reassembly Includes All Components/Accessories	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E0640	Patient Lift Fixed System Includes All Components/Accessories	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-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 (Predetermination) 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 (Predetermination) to avoid post-service review.	_	_	_
E0650	Pneuma compresor non-segment	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E0651	Pneum compressor segmental	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) to avoid post-service review.	_	_	_
E0655	Pneumatic appliance half arm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E0656	Segmental pneumatic trunk	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E0657	Segmental pneumatic chest	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E0660	Pneumatic appliance full leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E0665	Pneumatic appliance full arm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E0666	Pneumatic appliance half leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E0667	Seg pneumatic appl full leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) 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 (Predetermination) 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 (Predetermination) to avoid post-service review.	_	_	_
E0671	Pressure pneum appl full leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) 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 (Predetermination) 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).	_	_	_
E0676	Inter limb compress dev NOS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E0676	Inter limb compress dev NOS	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
E0677	Non pneum seq comp trunk	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	7/1/2023	_	Add effective 07/01/2023
E0691	Uvl pnl 2 sq ft or less	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) 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 (Predetermination) 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 (Predetermination) to avoid post-service review.	_	_	_
E0720	Transcutaneous Electrical Nerve Stimulation (Tens) Device Two Lead Localized Stimulation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E0730	Transcutaneous Electrical Nerve Stimulation (Tens) Device Four Or More Leads For Multiple Nerve Stimulation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E0731	Form Fitting Conductive Garment For Delivery Of Tens Or Nmes (With Conductive Fibers Separated From The Patient'S Skin By Layers Of Fabric)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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).	_	_	_
E0744	Neuromuscular Stimulator For Scoliosis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E0745	Neuromuscular stimulator electronic shock unit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E0746	Electromyograph biofeedback	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
E0747	Elec osteogen stim not spine	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E0748	Osteogenesis stimulator electrical non-invasive spinal applications	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E0749	Osteogenesis stimulator electrical surgically implanted	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_

E0760	Osteogen ultrasound stimltor	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E0761	Nontherm electromgntc device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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).	_	_	_
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).	_	_	_
E0765	Fda approved nerve stimulator with replaceable batteries for treatment of nausea and vomiting	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E0766	Elec stim cancer treatment	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
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 (Predetermination) to avoid post-service review.	_	_	_
E0770	Functional electric stim NOS	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
E0781	External ambulatory infus pu	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	9/30/2023	Retire effective 09/30/2023
E0784	External Ambulatory Infusion Pump Insulin	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E0787	External ambulatory infusion pump insulin dosage rate adjustment using therapeutic continuous glucose sensing	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service 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).	_	_	_
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).	_	_	_

E0935	Continuous Passive Motion Exercise Device For Use On Knee Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
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).	_	_	_
E0950	Tray	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E0955	Cushioned headrest	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E0958	Manual wheelchair accessory one-arm drive attachment each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E0961	Manual wheelchair accessory wheel lock brake extension (handle) each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E0968	Commode seat wheelchair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E0969	Wheelchair narrowing device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E0971	MANUAL WHEELCHAIR ACCESSORY ANTI-TIPPING DEVICE EACH	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E0973	Wheelchair accessory adjustable height detachable armrest complete assembly each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E0974	Manual wheelchair accessory anti-rollback device each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E0981	Seat upholstery replacement	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E0982	Back upholstery replacement	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E0983	Add pwr joystick	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E0984	Add pwr tiller	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) 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 (Predetermination) to avoid post-service review.	_	_	_
E0988	MANUAL WHEELCHAIR ACCESSORY LEVER-ACTIVATED WHEEL DRIVE PAIR	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_

E0990	Wheelchair elevating leg res	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E0992	Wheelchair solid seat insert	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E1002	Pwr seat tilt	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E1003	Pwr seat recline	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E1004	Pwr seat recline mech	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E1005	Pwr seat recline pwr	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E1006	Pwr seat combo w/o shear	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E1007	Pwr seat combo w/shear	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) to avoid post-service review.	_	_	_
E1009	Add mech leg elevation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E1010	Add pwr leg elevation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) to avoid post-service review.	_	_	_
E1014	Reclining back addition to pediatric size wheelchair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E1028	W/c manual swingaway	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E1031	Rollabout Chair Any And All Types With Castors 5 Or Greater	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E1035	Multi-Positional Patient Transfer System With Integrated Seat Operated By Care Giver Patient Weight Capacity Up To And Including 300 Lbs	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E1036	Multi-Positional Patient Transfer System Extra-Wide With Integrated Seat Operated By Caregiver Patient Weight Capacity Greater Than 300 Lbs	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E1037	Transport Chair Pediatric Size	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_

E1038	Transport Chair Adult Size Patient Weight Capacity Up To And Including 300 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E1039	Transport Chair Adult Size Heavy Duty Patient Weight Capacity Greater Than 300 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E1050	Fully-Reclining Wheelchair Fixed Full Length Arms Swing Away Detachable Elevating Leg Rests	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E1060	Fully-Reclining Wheelchair Detachable Arms Desk Or Full Length Swing Away Detachable Elevating Legrests	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E1070	Fully-Reclining Wheelchair Detachable Arms (Desk Or Full Length) Swing Away Detachable Footrest	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E1083	Hemi-wheelchair fixed arms	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E1084	Hemi-Wheelchair Detachable Arms Desk Or Full Length Arms Swing Away Detachable Elevating Leg Rests	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E1085	Hemi-wheelchair fixed arms	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E1086	Hemi-Wheelchair Detachable Arms Desk Or Full Length Swing Away Detachable Footrests	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E1087	Wheelchair lightwt fixed arm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E1088	High Strength Lightweight Wheelchair Detachable Arms Desk Or Full Length Swing Away Detachable Elevating Leg Rests	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E1089	High Strength Lightweight Wheelchair Fixed Length Arms Swing Away Detachable Footrest	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E1090	High Strength Lightweight Wheelchair Detachable Arms Desk Or Full Length Swing Away Detachable Foot Rests	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E1092	Wide Heavy Duty Wheel Chair Detachable Arms (Desk Or Full Length) Swing Away Detachable Elevating Leg Rests	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E1093	Wide Heavy Duty Wheelchair Detachable Arms Desk Or Full Length Arms Swing Away Detachable Footrests	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_

E1100	Semi-Reclining Wheelchair Fixed Full Length Arms Swing Away Detachable Elevating Leg Rests	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E1110	Semi-Reclining Wheelchair Detachable Arms (Desk Or Full Length) Elevating Leg Rest	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E1130	Standard Wheelchair Fixed Full Length Arms Fixed Or Swing Away Detachable Footrests	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E1140	Wheelchair Detachable Arms Desk Or Full Length Swing Away Detachable Footrests	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E1150	Wheelchair Detachable Arms Desk Or Full Length Swing Away Detachable Elevating Legrests	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E1160	Wheelchair Fixed Full Length Arms Swing Away Detachable Elevating Legrests	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E1161	Manual Adult Size Wheelchair Includes Tilt In Space	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E1170	Whlchr ampu fxd arm leg rest	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E1171	Wheelchair amputee w/o leg r	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E1172	Wheelchair amputee detach ar	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E1180	Wheelchair amputee w/ foot r	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E1190	Amputee Wheelchair Detachable Arms (Desk Or Full Length) Swing Away Detachable Elevating Legrests	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E1195	Wheelchair amputee heavy dut	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E1200	Wheelchair amputee fixed arm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E1220	Whlchr special size/constrc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E1221	Wheelchair spec size w foot	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E1222	Wheelchair With Fixed Arm Elevating Legrests	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E1223	Wheelchair With Detachable Arms Footrests	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_

E1224	Wheelchair With Detachable Arms Elevating Legrests	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E1225	Manual semi-reclining back	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E1226	Manual fully reclining back	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E1227	Wheelchair spec sz spec ht a	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E1228	Wheelchair spec sz spec ht b	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E1229	Pediatric wheelchair NOS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E1229	Pediatric wheelchair NOS	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
E1230	Power operated vehicle	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E1231	Rigid ped w/c tilt-in-space	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E1232	Wheelchair Pediatric Size Tilt-In-Space Folding Adjustable With Seating System	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E1233	Wheelchair Pediatric Size Tilt-In-Space Rigid Adjustable Without Seating System	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E1234	Wheelchair Pediatric Size Tilt-In-Space Folding Adjustable Without Seating System	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E1235	Wheelchair Pediatric Size Rigid Adjustable With Seating System	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E1236	Wheelchair Pediatric Size Folding Adjustable With Seating System	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E1237	Wheelchair Pediatric Size Rigid Adjustable Without Seating System	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E1238	Wheelchair Pediatric Size Folding Adjustable Without Seating System	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E1239	Ped power wheelchair NOS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E1239	Ped power wheelchair NOS	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
E1240	Lightweight Wheelchair Detachable Arms (Desk Or Full Length) Swing Away Detachable Elevating Legrest	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_

E1250	Lightweight Wheelchair Fixed Full Length Arms Swing Away Detachable Footrest	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E1260	Lightweight Wheelchair Detachable Arms (Desk Or Full Length) Swing Away Detachable Footrest	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E1270	Lightweight Wheelchair Fixed Full Length Arms Swing Away Detachable Elevating Legrests	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E1280	Heavy Duty Wheelchair Detachable Arms (Desk Or Full Length) Elevating Legrests	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E1285	Wheelchair heavy duty fixed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E1290	Heavy Duty Wheelchair Detachable Arms (Desk Or Full Length) Swing Away Detachable Footrest	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E1295	Wheelchair heavy duty fixed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E1296	Special Wheelchair Seat Height From Floor	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E1297	Special Wheelchair Seat Depth By Upholstery	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E1298	Special Wheelchair Seat Depth And/Or Width By Construction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E1300	Whirlpool portable	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
E1310	Whirlpool non-portable	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
E1399	Durable medical equipment mi	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
E1570	Adjustable chair for esrd patients	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
E1629	Tablo for dialysis service	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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).	_	_	_
E1639	Scale each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
E1699	Dialysis equipment noc	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
E1700	Jaw motion rehab system	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, 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).	_	_	_

E1902	Communication Board Non-Electronic Augmentative Or Alternative Communication Device	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
E1905	Vr Cbt Therapy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/1/2023	_	Add effective 04/01/2023
E2120	Pulse Generator System For Tympanic Treatment Of Inner Ear Endolymphatic Fluid	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2201	Man w/ch acc seat w>=20<24	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2202	Seat width 24-27 in	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2203	Frame depth less than 22 in	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2204	Frame depth 22 to 25 in	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2206	Man wc whl lock comp repl ea	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2207	Crutch and cane holder	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
E2209	Arm trough each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2211	Pneumatic propulsion tire	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2212	Pneumatic prop tire tube	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2213	Pneumatic prop tire insert	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2214	Pneumatic caster tire each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2215	Pneumatic caster tire tube	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2216	Foam filled propulsion tire	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2217	Foam filled caster tire each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2218	Foam propulsion tire each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2219	Foam caster tire any size ea	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2220	Solid propuls tire repl ea	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2221	Solid caster tire repl each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_

E2222	Solid caster integ whl repl	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2228	Mwc acc wheelchair brake	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2230	Manual standing system	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2231	Solid seat support base	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2291	Planar back for ped size wc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2292	Planar seat for ped size wc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2293	Contour back for ped size wc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2294	Contour seat for ped size wc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2295	Ped dynamic seating frame	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2300	Pwr seat elevation sys	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
E2301	Pwr standing	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
E2310	Electro connect btw control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) to avoid post-service review.	_	_	_
E2312	Mini-prop remote joystick	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2313	PWC harness expand control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2321	Hand interface joystick	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2322	Mult mech switches	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2323	Special joystick handle	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2324	Chin cup interface	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2325	Sip and puff interface	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2326	Breath tube kit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_

E2327	Head control interface mech	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2328	Head/extremity control inter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2329	Head control nonproportional	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2330	Head control proximity switc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2331	Attendant control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) 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 (Predetermination) to avoid post-service review.	_	_	_
E2342	W/c dpth 20-21 in seat frame	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) to avoid post-service review.	_	_	_
E2351	Electronic SGD interface	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
E2358	POWER WHEELCHAIR ACCESSORY GROUP 34 NON-SEALED LEAD ACID BATTERY EACH	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2359	POWER WHEELCHAIR ACCESSORY GROUP 34 SEALED LEAD ACID BATTERY EACH (E.G. GEL CELL ABSORBED GLASSMAT)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2360	22nf nonsealed leadacid	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2361	22nf sealed leadacid battery	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2362	Gr24 nonsealed leadacid	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2363	Gr24 sealed leadacid battery	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2364	U1nonsealed leadacid battery	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2365	U1 sealed leadacid battery	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2366	Battery charger single mode	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2367	Battery charger dual mode	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_

E2371	Gr27 sealed leadacid battery	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2372	Gr27 non-sealed leadacid	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) 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 (Predetermination) to avoid post-service review.	_	_	_
E2375	Non-expandable controller	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2376	Expandable controller repl	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2377	Expandable controller initl	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2381	POWER WHEELCHAIR ACCESSORY PNEUMATIC DRIVE WHEEL TIRE ANY SIZE REPLACEMENT ONLY EACH	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2382	POWER WHEELCHAIR ACCESSORY TUBE FOR PNEUMATIC DRIVE WHEEL TIRE ANY SIZE REPLACEMENT ONLY EACH	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2383	POWER WHEELCHAIR ACCESSORY INSERT FOR PNEUMATIC DRIVE WHEEL TIRE (REMOVABLE) ANY TYPE ANY SIZE REPLACEMENT ONLY EACH	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2384	POWER WHEELCHAIR ACCESSORY PNEUMATIC CASTER TIRE ANY SIZE REPLACEMENT ONLY EACH	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2385	POWER WHEELCHAIR ACCESSORY TUBE FOR PNEUMATIC CASTER TIRE ANY SIZE REPLACEMENT ONLY EACH	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2386	POWER WHEELCHAIR ACCESSORY FOAM FILLED DRIVE WHEEL TIRE ANY SIZE REPLACEMENT ONLY EACH	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2387	POWER WHEELCHAIR ACCESSORY FOAM FILLED CASTER TIRE ANY SIZE REPLACEMENT ONLY EACH	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2388	POWER WHEELCHAIR ACCESSORY FOAM DRIVE WHEEL TIRE ANY SIZE REPLACEMENT ONLY EACH	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2389	POWER WHEELCHAIR ACCESSORY FOAM CASTER TIRE ANY SIZE REPLACEMENT ONLY EACH	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_

E2394	POWER WHEELCHAIR ACCESSORY DRIVE WHEEL EXCLUDES TIRE ANY SIZE REPLACEMENT ONLY EACH	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2395	POWER WHEELCHAIR ACCESSORY CASTER WHEEL EXCLUDES TIRE ANY SIZE REPLACEMENT ONLY EACH	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2397	Pwc acc lith-based battery	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2402	Neg press wound therapy pump	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2500	SGD digitized pre-rec <=8min	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
E2502	SGD prerec msg >8min <=20min	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
E2504	SGD prerec msg>20min <=40min	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
E2506	SGD prerec msg > 40 min	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
E2508	SGD spelling phys contact	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
E2510	SGD w multi methods msg/accs	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
E2511	SGD sftwre prgrm for PC/PDA	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
E2512	SGD accessory mounting sys	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
E2599	SGD accessory noc	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
E2601	Gen w/c cushion wdth < 22 in	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2602	Gen w/c cushion wdth >=22 in	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2603	Skin protect wc cus wd <22in	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2604	Skin protect wc cus wd>=22in	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2605	Position wc cush wdth <22 in	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2606	Position wc cush wdth>=22 in	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2607	Skin pro/pos wc cus wd <22in	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2608	Skin pro/pos wc cus wd>=22in	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2609	Custom fabricate w/c cushion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_

E2610	Wheelchair Seat Cushion Powered	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2611	Gen use back cush wdth <22in	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2612	Gen use back cush wdth>=22in	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2613	Position back cush wd <22in	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2614	Position back cush wd>=22in	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2615	Pos back post/lat wdth <22in	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2616	Pos back post/lat wdth>=22in	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2617	Custom fab w/c back cushion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2619	REPLACEMENT COVER FOR WHEELCHAIR SEAT CUSHION OR BACK CUSHION EACH	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2620	WC planar back cush wd <22in	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2621	WC planar back cush wd>=22in	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2622	Adj skin pro w/c cus wd<22in	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2623	Adj skin pro wc cus wd>=22in	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2624	Adj skin pro/pos cus<22in	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2625	Adj skin pro/pos wc cus>=22	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2626	WHEELCHAIR ACCESSORY SHOULDER ELBOW MOBILE ARM SUPPORT ATTACHED TO WHEELCHAIR BALANCED ADJUSTABLE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2627	WHEELCHAIR ACCESSORY SHOULDER ELBOW MOBILE ARM SUPPORT ATTACHED TO WHEELCHAIR BALANCED ADJUSTABLE RANCHO TYPE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2628	WHEELCHAIR ACCESSORY SHOULDER ELBOW MOBILE ARM SUPPORT ATTACHED TO WHEELCHAIR BALANCED RECLINING	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_

E2629	WHEELCHAIR ACCESSORY SHOULDER ELBOW MOBILE ARM SUPPORT ATTACHED TO WHEELCHAIR BALANCED FRICTION ARM SUPPORT (FRICTION DAMPENING TO PROXIMAL AND DISTAL JOINTS)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2630	WHEELCHAIR ACCESSORY SHOULDER ELBOW MOBILE ARM SUPPORT MONOSUSPENSION ARM AND HAND SUPPORT OVERHEAD ELBOW FOREARM HAND SLING SUPPORT YOKE TYPE SUSPENSION SUPPORT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2631	WHEELCHAIR ACCESSORY ADDITION TO MOBILE ARM SUPPORT ELEVATING PROXIMAL ARM	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2632	WHEELCHAIR ACCESSORY ADDITION TO MOBILE ARM SUPPORT OFFSET OR LATERAL ROCKER ARM WITH ELASTIC BALANCE CONTROL	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2633	WHEELCHAIR ACCESSORY ADDITION TO MOBILE ARM SUPPORT SUPINATOR	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
G0029	Tobacco screening not performed or tobacco cessation intervention not provided during the measurement period or in the six months prior to the measurement period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
G0030	Patient screened for tobacco use and received tobacco cessation intervention during the measurement period or in the six months prior to the measurement period (counseling pharmacotherapy or both) if identified as a tobacco user	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
G0031	Palliative care services given to patient any time during the measurement period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
G0032	Two or more antipsychotic prescriptions ordered for patients who had a diagnosis of schizophrenia schizoaffective disorder or bipolar disorder on or between january 1 of the year prior to the measurement period and the index prescription start date (ipsd) for antipsychotics	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_

G0033	Two or more benzodiazepine prescriptions ordered for patients who had a diagnosis of seizure disorders rapid eye movement sleep behavior disorder benzodiazepine withdrawal ethanol withdrawal or severe generalized anxiety disorder on or between january 1 of the year prior to the measurement period and the ipsd for benzodiazepines	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G0034	Patients receiving palliative care during the measurement period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G0035	Patient has any emergency department encounter during the performance period with place of service indicator 23	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G0036	Patient or care partner decline assessment	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G0037	On date of encounter patient is not able to participate in assessment or screening including non-verbal patients delirious severely aphasic severely developmentally delayed severe visual or hearing impairment and for those patients no knowledgeable informant available	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G0038	Clinician determines patient does not require referral	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G0039	Patient not referred reason not otherwise specified	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G0040	Patient already receiving physical/occupational/speech/recreational therapy during the measurement period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G0041	Patient and/or care partner decline referral	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G0042	Referral to physical occupational speech or recreational therapy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G0043	Patients with mechanical prosthetic heart valve	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G0044	Patients with moderate or severe mitral stenosis	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G0045	Clinical follow-up and mrs score assessed at 90 days following endovascular stroke intervention	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G0046	Clinical follow-up and mrs score not assessed at 90 days following endovascular stroke intervention	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G0047	Pediatric patient with minor blunt head trauma and pecarn prediction criteria are not assessed	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	
G0048	Patients who receive palliative care services any time during the intake period through the end of the measurement year	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	
G0049	With maintenance hemodialysis (in-center and home hd) for the complete reporting month	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	
G0050	Patients with a catheter that have limited life expectancy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	
G0051	Patients under hospice care in the current reporting month	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	
G0052	Patients on peritoneal dialysis for any portion of the reporting month	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	
G0053	Advancing rheumatology patient care mips value pathways	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	
G0054	Coordinating stroke care to promote prevention and cultivate positive outcomes mips value pathways	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	
G0055	Advancing care for heart disease mips value pathways	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	
G0056	Optimizing chronic disease management mips value pathways	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	
G0057	Proposed adopting best practices and promoting patient safety within emergency medicine mips value pathways	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	
G0058	Improving care for lower extremity joint repair mips value pathways	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	
G0059	Patient safety and support of positive experiences with anesthesia mips value pathways	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	
G0060	Allergy/immunology mips specialty set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	
G0061	Anesthesiology mips specialty set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	
G0062	Audiology mips specialty set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	
G0063	Cardiology mips specialty set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	
G0064	Certified nurse midwife mips specialty set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	
G0065	Chiropractic medicine mips specialty set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	
G0066	Clinical social work mips specialty set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	
G0067	Dentistry mips specialty set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	

G0068	Professional services for the administration of anti-infective pain management chelation pulmonary hypertension inotropic or other intravenous infusion drug or biological (excluding chemotherapy or other highly complex drug or biological) for each infusion drug administration calendar day in the individual's home each 15 minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G0069	Professional services for the administration of subcutaneous immunotherapy or other subcutaneous infusion drug or biological for each infusion drug administration calendar day in the individual's home each 15 minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G0070	Professional services for the administration of intravenous chemotherapy or other intravenous highly complex drug or biological infusion for each infusion drug administration calendar day in the individual's home each 15 minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G0076	Brief (20 minutes) care management home visit for a new patient. for use only in a medicare-approved cmmi model. (services must be furnished within a beneficiary's home domiciliary rest home assisted living and/or nursing facility)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G0077	Limited (30 minutes) care management home visit for a new patient. for use only in a medicare-approved cmmi model. (services must be furnished within a beneficiary's home domiciliary rest home assisted living and/or nursing facility)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G0078	Moderate (45 minutes) care management home visit for a new patient. for use only in a medicare-approved cmmi model. (services must be furnished within a beneficiary's home domiciliary rest home assisted living and/or nursing facility)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G0079	Comprehensive (60 minutes) care management home visit for a new patient. for use only in a medicare-approved cmmi model. (services must be furnished within a beneficiary's home domiciliary rest home assisted living and/or nursing facility)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G0080	Extensive (75 minutes) care management home visit for a new patient. for use only in a medicare-approved cmmi model. (services must be furnished within a beneficiary's home domiciliary rest home assisted living and/or nursing facility)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G0081	Brief (20 minutes) care management home visit for an existing patient. for use only in a medicare-approved cmmi model. (services must be furnished within a beneficiary's home domiciliary rest home assisted living and/or nursing facility)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G0082	Limited (30 minutes) care management home visit for an existing patient. for use only in a medicare-approved cmmi model. (services must be furnished within a beneficiary's home domiciliary rest home assisted living and/or nursing facility)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G0083	Moderate (45 minutes) care management home visit for an existing patient. for use only in a medicare-approved cmmi model. (services must be furnished within a beneficiary's home domiciliary rest home assisted living and/or nursing facility)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G0084	Comprehensive (60 minutes) care management home visit for an existing patient. for use only in a medicare-approved cmmi model. (services must be furnished within a beneficiary's home domiciliary rest home assisted living and/or nursing facility)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G0085	Extensive (75 minutes) care management home visit for an existing patient. for use only in a medicare-approved cmmi model. (services must be furnished within a beneficiary's home domiciliary rest home assisted living and/or nursing facility)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
G0086	Limited (30 minutes) care management home care plan oversight. for use only in a medicare-approved cmmi model. (services must be furnished within a beneficiary's home domiciliary rest home assisted living and/or nursing facility)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
G0087	Comprehensive (60 minutes) care management home care plan oversight. for use only in a medicare-approved cmmi model. (services must be furnished within a beneficiary's home domiciliary rest home assisted living and/or nursing facility)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
G0088	Professional services initial visit for the administration of anti-infective pain management chelation pulmonary hypertension inotropic or other intravenous infusion drug or biological (excluding chemotherapy or other highly complex drug or biological) for each infusion drug administration calendar day in the individual's home each 15 minutes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
G0089	Professional services initial visit for the administration of subcutaneous immunotherapy or other subcutaneous infusion drug or biological for each infusion drug administration calendar day in the individual's home each 15 minutes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
G0090	Professional services initial visit for the administration of intravenous chemotherapy or other highly complex infusion drug or biological for each infusion drug administration calendar day in the individual's home each 15 minutes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_

G0127	Trimming Of Dystrophic Nails Any Number	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	9/30/2023	Retire effective 09/30/2023
G0151	Services Performed By A Qualified Physical Therapist In The Home Health Or Hospice Setting Each 15 Minutes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
G0152	Services Performed By A Qualified Occupational Therapist In The Home Health Or Hospice Setting Each 15 Minutes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
G0153	Services Performed By A Qualified Speech-Language Pathologist In The Home Health Or Hospice Setting Each 15 Minutes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
G0156	SERVICES OF HOME HEALTH/HOSPICE AIDE IN HOME HEALTH OR HOSPICE SETTINGS EACH 15 MINUTES	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
G0157	Services Performed By A Qualified Physical Therapist Assistant In The Home Health Or Hospice Setting Each 15 Minutes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
G0158	Services Performed By A Qualified Occupational Therapist Assistant In The Home Health Or Hospice Setting Each 15 Minutes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
G0159	Services Performed By A Qualified Physical Therapist In The Home Health Setting In The Establishment Or Delivery Of A Safe And Effective Physical Therapy Maintenance Program Each 15 Minutes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
G0160	Services Performed By A Qualified Occupational Therapist In The Home Health Setting In The Establishment Or Delivery Of A Safe And Effective Occupational Therapy Maintenance Program Each 15 Minutes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
G0161	Services Performed By A Qualified Speech-Language Pathologist In The Home Health Setting In The Establishment Or Delivery Of A Safe And Effective Speech-Language Pathology Maintenance Program Each 15 Minutes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
G0176	OPPS/PHP;activity therapy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_

G0180	Physician or allowed practitioner certification for Medicare-covered home health services under a home health plan of care (patient not present) including contacts with home health agency and review of reports of patient status required by physicians and allowed practitioners to affirm the initial implementation of the plan of care	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
G0235	Pet imaging any site not otherwise specified	Unlisted Procedure; May require Prior Authorization per contract agreement.	_	_	_
G0245	Initial physician evaluation and management of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation (lops) which must include: (1) the diagnosis of lops (2) a patient history (3) a physical examination that consists of at least the following elements: (a) visual inspection of the forefoot hindfoot and toe web spaces (b)evaluation of a protective sensation (c) evaluation of foot structure and biomechanics (d) evaluation of vascular status and skin integrity and (e) evaluation and recommendation of footwear and (4) patient education	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
G0246	Follow-up physician evaluation and management of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation (lops) to include at least the following: (1) a patient history (2) a physical examination that includes: (a) visual inspection of the forefoot hindfoot and toe web spaces (b) evaluation of protective sensation (c) evaluation of foot structure and biomechanics (d) evaluation of vascular status and skin integrity and (e) evaluation and recommendation of footwear and (3) patient education	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_

G0247	Routine foot care by a physician of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation (lops) to include the local care of superficial wounds (i. E. Superficial to muscle and fascia) and at least the following if present: (1) local care of superficial wounds (2) debridement of corns and calluses and (3) trimming and debridement of nails	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	9/30/2023	Retire effective 09/30/2023
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).	_	_	_
G0260	Injection procedure for sacroiliac joint; provision of anesthetic steroid and/or other therapeutic agent with or without arthrography	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
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 (Predetermination) to avoid post-service review.	_	_	_
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).	_	_	_
G0299	Direct skilled nursing services of a registered nurse (rn) in the home health or hospice setting each 15 minutes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
G0300	Direct skilled nursing services of a license practical nurse (lpn) in the home health or hospice setting each 15 minutes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
G0310	Immunize counsel 5-15 min	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
G0311	Immunize counsel 16-30 mins	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
G0312	Immunize couns < 21yr 5-15 m	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
G0313	Immunize couns < 21yr 6-30 m	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
G0314	Counsel immune <21 16-30 m	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
G0315	Counsel immune <21 5-15 m	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_

G0316	Prolong inpt eval add15 m	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
G0317	Prolong nursin fac eval 15m	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
G0318	Prolong home eval add 15m	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
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).	_	_	_
G0330	Facility svs dental rehab	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
G0333	Pharmacy Dispensing Fee For Inhalation Drug(S); Initial 30-Day Supply As A Beneficiary	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
G0341	Percutaneous islet celltrans	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
G0342	Laparoscopy islet cell trans	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
G0343	Laparotomy islet cell transp	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
G0400	Home sleep test (HST) with type IV portable monitor unattended; minimum of 3 channels	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
G0416	Prostate biopsy any mthd	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
G0420	FACE-TO-FACE EDUCATIONAL SERVICES RELATED TO THE CARE OF CHRONIC KIDNEY DISEASE; INDIVIDUAL PER SESSION PER ONE HOUR	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
G0421	FACE-TO-FACE EDUCATIONAL SERVICES RELATED TO THE CARE OF CHRONIC KIDNEY DISEASE; GROUP PER SESSION PER ONE HOUR	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
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 (Predetermination) to avoid post-service review.	_	_	_
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 (Predetermination) 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).	_	_	_
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 (Predetermination) to avoid post-service review.	_	_	_

G0448	Insertion Or Replacement Of A Permanent Pacing Cardioverter-Defibrillator System With Transvenous Lead(S) Single Or Dual Chamber With Insertion Of Pacing Electrode Cardiac Venous System For Left Ventricular Pacing	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
G0453	Continuous intraoperative neurophysiology monitoring from outside the operating room (remote or nearby) per patient (attention directed exclusively to one patient) each 15 minutes (list in addition to primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	12/31/2022	Retired effective 12/31/2022
G0455	Fecal microbiota prep instil	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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).	_	_	_
G0490	Face-to-face home health nursing visit by a Rural Health Clinic (RHC) or Federally Qualified Health Center (FQHC) in an area with a shortage of home health agencies. (Services limited to RN or LPN only).	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
G0493	Skilled services of a registered nurse (rn) for the observation and assessment of the patient's condition each 15 minutes (the change in the patient's condition requires skilled nursing personnel to identify and evaluate the patient's need for possible modification of treatment in the home health or hospice setting)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
G0494	Skilled services of a licensed practical nurse (lpn) for the observation and assessment of the patient's condition each 15 minutes (the change in the patient's condition requires skilled nursing personnel to identify and evaluate the patient's need for possible modification of treatment in the home health or hospice setting)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_

G0495	Skilled services of a registered nurse (rn) in the training and/or education of a patient or family member in the home health or hospice setting each 15 minutes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
G0496	Skilled services of a licensed practical nurse (lpn) in the training and/or education of a patient or family member in the home health or hospice setting each 15 minutes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
G0501	Resource-intensive services for patients for whom the use of specialized mobility-assistive technology (such as adjustable height chairs or tables patient lift and adjustable padded leg supports) is medically necessary and used during the provision of an office/outpatient evaluation and management visit (list separately in addition to primary service)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
G0516	insert drug del implant >=4	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
G0517	Removal Of Non-Biodegradable Drug Delivery Implants 4 Or More (Services For Subdermal Implants)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
G0518	Remove w insert drug implant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
G0913	IMPROVEMENT IN VISUAL FUNCTION ACHIEVED WITHIN 90 DAYS FOLLOWING CATARACT SURGERY	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
G0914	PATIENT CARE SURVEY WAS NOT COMPLETED BY PATIENT	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
G0915	IMPROVEMENT IN VISUAL FUNCTION NOT ACHIEVED WITHIN 90 DAYS FOLLOWING CATARACT SURGERY	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
G0916	SATISFACTION WITH CARE ACHIEVED WITHIN 90 DAYS FOLLOWING CATARACT SURGERY	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
G0917	Patient care survey was not completed by patient	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
G1001	Clinical decision support mechanism evicore as defined by the medicare appropriate use criteria program	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_

G1002	Clinical decision support mechanism medcurrent as defined by the medicare appropriate use criteria program	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G1003	Clinical decision support mechanism medicalis as defined by the medicare appropriate use criteria program	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G1004	Clinical decision support mechanism national decision support company as defined by the medicare appropriate use criteria program	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G1007	Clinical decision support mechanism aim specialty health as defined by the medicare appropriate use criteria program	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G1008	Clinical decision support mechanism cranberry peak as defined by the medicare appropriate use criteria program	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G1010	Clinical decision support mechanism stanson as defined by the medicare appropriate use criteria program	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G1011	Clinical decision support mechanism qualified tool not otherwise specified as defined by the medicare appropriate use criteria program	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G1012	Clinical decision support mechanism agilemd as defined by the medicare appropriate use criteria program	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G1013	Clinical decision support mechanism evidencecare imagingcare as defined by the medicare appropriate use criteria program	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G1014	Clinical decision support mechanism inveniqa semantic answers in medicine as defined by the medicare appropriate use criteria program	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G1015	Clinical decision support mechanism reliant medical group as defined by the medicare appropriate use criteria program	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G1016	Clinical decision support mechanism speed of care as defined by the medicare appropriate use criteria program	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G1017	Clinical decision support mechanism healthhelp as defined by the medicare appropriate use criteria program	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G1018	Clinical decision support mechanism infinx as defined by the medicare appropriate use criteria program	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G1019	Clinical decision support mechanism logicnets as defined by the medicare appropriate use criteria program	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G1020	Clinical decision support mechanism curbside clinical augmented workflow as defined by the medicare appropriate use criteria program	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G1021	Clinical decision support mechanism ehealthline clinical decision support mechanism as defined by the medicare appropriate use criteria program	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G1022	Clinical decision support mechanism intermountain clinical decision support mechanism as defined by the medicare appropriate use criteria program	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G1023	Clinical decision support mechanism persivia clinical decision support as defined by the medicare appropriate use criteria program	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G1024	Clinical decision support mechanism radrite as defined by the medicare appropriate use criteria program	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G1025	Patient-months where there are more than one medicare capitated payment (mcp) provider listed for the month	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G1026	The number of adult patient-months in the denominator who were on maintenance hemodialysis using a catheter continuously for three months or longer under the care of the same practitioner or group partner as of the last hemodialysis session of the reporting month	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G1027	The number of adult patient-months in the denominator who were on maintenance hemodialysis under the care of the same practitioner or group partner as of the last hemodialysis session of the reporting month using a catheter continuously for less than three months	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G2000	Blinded administration of convulsive therapy procedure either electroconvulsive therapy (ect current covered gold standard) or magnetic seizure therapy (mst non-covered experimental therapy) performed in an approved ide-based clinical trial per treatment session	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G2001	Brief (20 minutes) in-home visit for a new patient post-discharge. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home domiciliary rest home assisted living and/or nursing facility within 90 days following discharge from an inpatient facility and no more than 9 times.)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G2002	Limited (30 minutes) in-home visit for a new patient post-discharge. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home domiciliary rest home assisted living and/or nursing facility within 90 days following discharge from an inpatient facility and no more than 9 times.)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G2003	Moderate (45 minutes) in-home visit for a new patient post-discharge. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home domiciliary rest home assisted living and/or nursing facility within 90 days following discharge from an inpatient facility and no more than 9 times.)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G2004	Comprehensive (60 minutes) in-home visit for a new patient post-discharge. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home domiciliary rest home assisted living and/or nursing facility within 90 days following discharge from an inpatient facility and no more than 9 times.)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G2005	Extensive (75 minutes) in-home visit for a new patient post-discharge. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home domiciliary rest home assisted living and/or nursing facility within 90 days following discharge from an inpatient facility and no more than 9 times.)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G2006	Brief (20 minutes) in-home visit for an existing patient post-discharge. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home domiciliary rest home assisted living and/or nursing facility within 90 days following discharge from an inpatient facility and no more than 9 times.)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G2007	Limited (30 minutes) in-home visit for an existing patient post-discharge. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home domiciliary rest home assisted living and/or nursing facility within 90 days following discharge from an inpatient facility and no more than 9 times.)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G2008	Moderate (45 minutes) in-home visit for an existing patient post-discharge. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home domiciliary rest home assisted living and/or nursing facility within 90 days following discharge from an inpatient facility and no more than 9 times.)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G2009	Comprehensive (60 minutes) in-home visit for an existing patient post-discharge. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home domiciliary rest home assisted living and/or nursing facility within 90 days following discharge from an inpatient facility and no more than 9 times.)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
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.	–	–	–
G2013	Extensive (75 minutes) in-home visit for an existing patient post-discharge. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home domiciliary rest home assisted living and/or nursing facility within 90 days following discharge from an inpatient facility and no more than 9 times.	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G2014	Limited (30 minutes) care plan oversight. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home domiciliary rest home assisted living and/or nursing facility within 90 days following discharge from an inpatient facility and no more than 9 times.)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G2015	Comprehensive (60 mins) home care plan oversight. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home domiciliary rest home assisted living and/or nursing facility within 90 days following discharge from an inpatient facility.)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
G2020	Services for high intensity clinical services associated with the initial engagement and outreach of beneficiaries assigned to the sip component of the pcf model (do not bill with chronic care management codes)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
G2021	Health care practitioners rendering treatment in place (tip)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
G2022	A model participant (ambulance supplier/provider) the beneficiary refuses services covered under the model (transport to an alternate destination/treatment in place)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
G2025	Payment for a telehealth distant site service furnished by a rural health clinic (rhc) or federally qualified health center (fqhc) only	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
G2066	Interrogation device evaluation(s) (remote) up to 30 days; implantable cardiovascular physiologic monitor system implantable loop recorder system or subcutaneous cardiac rhythm monitor system remote data acquisition(s) receipt of transmissions and technician review technical support and distribution of results	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
G2070	Medication assisted treatment buprenorphine (implant insertion); weekly bundle including dispensing and/or administration substance use counseling individual and group therapy and toxicology testing if performed (provision of the services by a medicare-enrolled opioid treatment program)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	2/14/2023	Retired effective 02/14/2023

G2071	Medication assisted treatment buprenorphine (implant removal); weekly bundle including dispensing and/or administration substance use counseling individual and group therapy and toxicology testing if performed (provision of the services by a medicare-enrolled opioid treatment program)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	2/14/2023	Retired effective 02/14/2023
G2072	Medication assisted treatment buprenorphine (implant insertion and removal); weekly bundle including dispensing and/or administration substance use counseling individual and group therapy and toxicology testing if performed (provision of the services by a medicare-enrolled opioid treatment program)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	2/14/2023	Retired effective 02/14/2023
G2081	Patients age 66 and older in institutional special needs plans (snp) or residing in long-term care with a pos code 32 33 34 54 or 56 for more than 90 consecutive days during the measurement period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
G2082	Visit esketamine 56m or less	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
G2083	Visit esketamine > 56m	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
G2090	Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period and a dispensed medication for dementia during the measurement period or the year prior to the measurement period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_

G2091	Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period and either one acute inpatient encounter with a diagnosis of advanced illness or two outpatient observation ed or nonacute inpatient encounters on different dates of service with an advanced illness diagnosis during the measurement period or the year prior to the measurement period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G2092	Angiotensin converting enzyme (ace) inhibitor or angiotensin receptor blocker (arb) or angiotensin receptor-neprilysin inhibitor (arni) therapy prescribed or currently being taken	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G2093	Documentation of medical reason(s) for not prescribing ace inhibitor or arb or arni therapy (e.g. hypotensive patients who are at immediate risk of cardiogenic shock hospitalized patients who have experienced marked azotemia allergy intolerance other medical reasons)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G2094	Documentation of patient reason(s) for not prescribing ace inhibitor or arb or arni therapy (e.g. patient declined other patient reasons)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G2096	Angiotensin converting enzyme (ace) inhibitor or angiotensin receptor blocker (arb) or angiotensin receptor-neprilysin inhibitor (arni) therapy was not prescribed reason not given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G2097	Episodes where the patient had a competing diagnosis on or within three days after the episode date (e.g. intestinal infection pertussis bacterial infection lyme disease otitis media acute sinusitis chronic sinusitis infection of the adenoids prostatitis cellulitis mastoiditis or bone infections acute lymphadenitis impetigo skin staph infections pneumonia/gonococcal infections venereal disease (syphilis chlamydia inflammatory diseases [female reproductive organs]) infections of the kidney cystitis or uti)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G2098	Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period and a dispensed medication for dementia during the measurement period or the year prior to the measurement period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G2099	Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period and either one acute inpatient encounter with a diagnosis of advanced illness or two outpatient observation ed or nonacute inpatient encounters on different dates of service with an advanced illness diagnosis during the measurement period or the year prior to the measurement period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G2100	Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period and a dispensed medication for dementia during the measurement period or the year prior to the measurement period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G2101	Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period and either one acute inpatient encounter with a diagnosis of advanced illness or two outpatient observation ed or nonacute inpatient encounters on different dates of service with an advanced illness diagnosis during the measurement period or the year prior to the measurement period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G2105	Patient age 66 or older in institutional special needs plans (snp) or residing in long-term care with pos code 32 33 34 54 or 56 for more than 90 consecutive days during the measurement period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G2106	Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period and a dispensed medication for dementia during the measurement period or the year prior to the measurement period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G2107	Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period and either one acute inpatient encounter with a diagnosis of advanced illness or two outpatient observation ed or nonacute inpatient encounters on different dates of service with an advanced illness diagnosis during the measurement period or the year prior to the measurement period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G2108	Patient age 66 or older in institutional special needs plans (snp) or residing in long-term care with pos code 32 33 34 54 or 56 for more than 90 consecutive days during the measurement period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G2109	Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period and a dispensed medication for dementia during the measurement period or the year prior to the measurement period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G2110	Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period and either one acute inpatient encounter with a diagnosis of advanced illness or two outpatient observation ed or nonacute inpatient encounters on different dates of service with an advanced illness diagnosis during the measurement period or the year prior to the measurement period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G2112	Patient receiving <=5 mg daily prednisone (or equivalent) or ra activity is worsening or glucocorticoid use is for less than 6 months	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G2113	Patient receiving >5 mg daily prednisone (or equivalent) for longer than 6 months and improvement or no change in disease activity	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G2115	Patients 66 - 80 years of age with at least one claim/encounter for frailty during the measurement period and a dispensed medication for dementia during the measurement period or the year prior to the measurement period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G2116	Patients 66 - 80 years of age with at least one claim/encounter for frailty during the measurement period and either one acute inpatient encounter with a diagnosis of advanced illness or two outpatient observation ed or nonacute inpatient encounters on different dates of service with an advanced illness diagnosis during the measurement period or the year prior to the measurement period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G2118	Patients 81 years of age and older with at least one claim/encounter for frailty during the measurement period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G2121	Depression anxiety apathy and psychosis assessed	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G2122	Depression anxiety apathy and psychosis not assessed	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G2125	Patients 81 years of age and older with at least one claim/encounter for frailty during the six months prior to the measurement period through december 31 of the measurement period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G2126	Patients 66 - 80 years of age with at least one claim/encounter for frailty during the measurement period and either one acute inpatient encounter with a diagnosis of advanced illness or two outpatient observation ed or nonacute inpatient encounters on different dates of service with an advanced illness diagnosis during the measurement period or the year prior to the measurement period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G2127	Patients 66 ? 80 years of age with at least one claim/encounter for frailty during the measurement period and a dispensed medication for dementia during the measurement period or the year prior to the measurement period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G2128	Documentation of medical reason(s) for not on a daily aspirin or other antiplatelet (e.g. history of gastrointestinal bleed intra-cranial bleed blood disorders idiopathic thrombocytopenic purpura (itp) gastric bypass or documentation of active anticoagulant use during the measurement period)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G2129	Procedure-related bp's not taken during an outpatient visit. examples include same day surgery ambulatory service center g.i. lab dialysis infusion center chemotherapy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G2136	Back pain measured by the visual analog scale (vas) or numeric pain scale at three months (6 - 20 weeks) postoperatively was less than or equal to 3.0 or back pain measured by the visual analog scale (vas) or numeric pain scale within three months preoperatively and at three months (6 - 20 weeks) postoperatively demonstrated an improvement of 5.0 points or greater	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G2137	Back pain measured by the visual analog scale (vas) or numeric pain scale at three months (6 - 20 weeks) postoperatively was greater than 3.0 and back pain measured by the visual analog scale (vas) or numeric pain scale within three months preoperatively and at three months (6 - 20 weeks) postoperatively demonstrated less than an improvement of 5.0 points	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G2138	Back pain as measured by the visual analog scale (vas) or numeric pain scale at one year (9 to 15 months) postoperatively was less than or equal to 3.0 or back pain measured by the visual analog scale (vas) or numeric pain scale within three months preoperatively and at one year (9 to 15 months) postoperatively demonstrated an improvement of 5.0 points or greater	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G2139	Back pain measured by the visual analog scale (vas) or numeric pain scale at one year (9 to 15 months) postoperatively was greater than 3.0 and back pain measured by the visual analog scale (vas) or numeric pain scale within three months preoperatively and at one year (9 to 15 months) postoperatively demonstrated less than an improvement of 5.0 points	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G2140	Leg pain measured by the visual analog scale (vas) or numeric pain scale at three months (6 - 20 weeks) postoperatively was less than or equal to 3.0 or leg pain measured by the visual analog scale (vas) or numeric pain scale within three months preoperatively and at three months (6 - 20 weeks) postoperatively demonstrated an improvement of 5.0 points or greater	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G2141	Leg pain measured by the visual analog scale (vas) or numeric pain scale at three months (6 - 20 weeks) postoperatively was greater than 3.0 and leg pain measured by the visual analog scale (vas) or numeric pain scale within three months preoperatively and at three months (6 - 20 weeks) postoperatively demonstrated less than an improvement of 5.0 points	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G2142	Functional status measured by the oswestry disability index (odi version 2.1a) at one year (9 to 15 months) postoperatively was less than or equal to 22 or functional status measured by the odi version 2.1a within three months preoperatively and at one year (9 to 15 months) postoperatively demonstrated an improvement of 30 points or greater	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G2143	Functional status measured by the oswestry disability index (odi version 2.1a) at one year (9 to 15 months) postoperatively was greater than 22 and functional status measured by the odi version 2.1a within three months preoperatively and at one year (9 to 15 months) postoperatively demonstrated an improvement of less than 30 points	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G2144	Functional status measured by the oswestry disability index (odi version 2.1a) at three months (6 ? 20 weeks) postoperatively was less than or equal to 22 or functional status measured by the odi version 2.1a within three months preoperatively and at three months (6 - 20 weeks) postoperatively demonstrated an improvement of 30 points or greater	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G2145	Functional status measured by the oswestry disability index (odi version 2.1a) at three months (6 - 20 weeks) postoperatively was greater than 22 and functional status measured by the odi version 2.1a within three months preoperatively and at three months (6 - 20 weeks) postoperatively demonstrated an improvement of less than 30 points	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G2146	Leg pain as measured by the visual analog scale (vas) or numeric pain scale at one year (9 to 15 months) postoperatively was less than or equal to 3.0 or leg pain measured by the visual analog scale (vas) or numeric pain scale within three months preoperatively and at one year (9 to 15 months) postoperatively demonstrated an improvement of 5.0 points or greater	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G2147	Leg pain measured by the visual analog scale (vas) or numeric pain scale at one year (9 to 15 months) postoperatively was greater than 3.0 and leg pain measured by the visual analog scale (vas) or numeric pain scale within three months preoperatively and at one year (9 to 15 months) postoperatively demonstrated less than an improvement of 5.0 points	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G2148	Multimodal pain management was used	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G2149	Documentation of medical reason(s) for not using multimodal pain management (e.g. allergy to multiple classes of analgesics intubated patient hepatic failure patient reports no pain during pacu stay other medical reason(s))	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G2150	Multimodal pain management was not used	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G2151	Documentation stating patient has a diagnosis of a degenerative neurological condition such as als ms or parkinson's diagnosed at any time before or during the episode of care	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G2152	Residual score for the neck impairment successfully calculated and the score was equal to zero (0) or greater than zero (> 0)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G2167	Residual score for the neck impairment successfully calculated and the score was less than zero (< 0)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G2168	Services performed by a physical therapist assistant in the home health setting in the delivery of a safe and effective physical therapy maintenance program each 15 minutes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	–	–	–
G2169	Services performed by an occupational therapist assistant in the home health setting in the delivery of a safe and effective occupational therapy maintenance program each 15 minutes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	–	–	–
G2172	All inclusive payment for services related to highly coordinated and integrated opioid use disorder (oud) treatment services furnished for the demonstration project	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G2173	Uri episodes where the patient had a comorbid condition during the 12 months prior to or on the episode date (e.g. tuberculosis neutropenia cystic fibrosis chronic bronchitis pulmonary edema respiratory failure rheumatoid lung disease)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G2174	Uri episodes when the patient had an active prescription of antibiotics in the 30 days prior to the episode date or is still active the same day of the encounter	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G2175	Episodes where the patient had a comorbid condition during the 12 months prior to or on the episode date (e.g. tuberculosis neutropenia cystic fibrosis chronic bronchitis pulmonary edema respiratory failure rheumatoid lung disease)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G2176	Outpatient ed or observation visits that result in an inpatient admission	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G2177	Acute bronchitis/bronchiolitis episodes when the patient had a new or refill prescription of antibiotics (table 1) in the 30 days prior to the episode date	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G2178	Clinician documented that patient was not an eligible candidate for lower extremity neurological exam measure for example patient bilateral amputee; patient has condition that would not allow them to accurately respond to a neurological exam (dementia alzheimer's etc.); patient has previously documented diabetic peripheral neuropathy with loss of protective sensation	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G2179	Clinician documented that patient had medical reason for not performing lower extremity neurological exam	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G2180	Clinician documented that patient was not an eligible candidate for evaluation of footwear as patient is bilateral lower extremity amputee	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G2181	Bmi not documented due to medical reason or patient refusal of height or weight measurement	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G2182	Patient receiving first-time biologic and/or immune response modifier therapy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G2183	Documentation patient unable to communicate and informant not available	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G2184	Patient does not have a caregiver	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G2185	Documentation caregiver is trained and certified in dementia care	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G2186	Patient /caregiver dyad has been referred to appropriate resources and connection to those resources is confirmed	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G2187	Patients with clinical indications for imaging of the head: head trauma	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G2188	Patients with clinical indications for imaging of the head: new or change in headache above 50 years of age	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G2189	Patients with clinical indications for imaging of the head: abnormal neurologic exam	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G2190	Patients with clinical indications for imaging of the head: headache radiating to the neck	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G2191	Patients with clinical indications for imaging of the head: positional headaches	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G2192	Patients with clinical indications for imaging of the head: temporal headaches in patients over 55 years of age	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G2193	Patients with clinical indications for imaging of the head: new onset headache in pre-school children or younger (<6 years of age)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G2194	Patients with clinical indications for imaging of the head: new onset headache in pediatric patients with disabilities for which headache is a concern as inferred from behavior	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G2195	Patients with clinical indications for imaging of the head: occipital headache in children	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G2196	Patient identified as an unhealthy alcohol user when screened for unhealthy alcohol use using a systematic screening method	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G2197	Patient screened for unhealthy alcohol use using a systematic screening method and not identified as an unhealthy alcohol user	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G2199	Patient not screened for unhealthy alcohol use using a systematic screening method	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G2200	Patient identified as an unhealthy alcohol user received brief counseling	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G2202	Patient did not receive brief counseling if identified as an unhealthy alcohol user	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G2204	Patients between 45 and 85 years of age who received a screening colonoscopy during the performance period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G2205	Patients with pregnancy during adjuvant treatment course	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G2206	Patient received adjuvant treatment course including both chemotherapy and her2-targeted therapy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G2207	Reason for not administering adjuvant treatment course including both chemotherapy and her2-targeted therapy (e.g. poor performance status (ecog 3-4; karnofsky <=50) cardiac contraindications insufficient renal function insufficient hepatic function other active or secondary cancer diagnoses other medical contraindications patients who died during initial treatment course or transferred during or after initial treatment course)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G2208	Patient did not receive adjuvant treatment course including both chemotherapy and her2-targeted therapy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G2209	Patient refused to participate	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G2210	Residual score for the neck impairment not measured because the patient did not complete the neck fs prom at initial evaluation and/or near discharge reason not given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G2250	Remote assessment of recorded video and/or images submitted by an established patient (e.g. store and forward) including interpretation with follow-up with the patient within 24 business hours not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G3002	Chronic pain mgmt 30 mins	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G3003	Chronic pain mgmt addl 15m	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G4000	Dermatology mips specialty set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G4001	Diagnostic radiology mips specialty set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G4002	Electrophysiology cardiac specialist mips specialty set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G4003	Emergency medicine mips specialty set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G4004	Endocrinology mips specialty set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G4005	Family medicine mips specialty set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G4006	Gastro-enterology mips specialty set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G4007	General surgery mips specialty set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G4008	Geriatrics mips specialty set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G4009	Hospitalists mips specialty set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G4010	Infectious disease mips specialty set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G4011	Internal medicine mips specialty set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G4012	Interventional radiology mips specialty set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G4013	Mental/behavioral and psychiatry mips specialty set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G4014	Nephrology mips specialty set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G4015	Neurology mips specialty set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G4016	Neurosurgical mips specialty set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G4017	Nutrition/dietician mips specialty set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G4018	Obstetrics/gynecology mips specialty set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G4019	Oncology/hematology mips specialty set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G4020	Ophthalmology/optometry mips specialty set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G4021	Orthopedic surgery mips specialty set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G4022	Otolaryngology mips specialty set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G4023	Pathology mips specialty set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G4024	Pediatrics mips specialty set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G4025	Physical medicine mips specialty set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G4026	Physical therapy/occupational therapy mips specialty set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G4027	Plastic surgery mips specialty set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G4028	Podiatry mips specialty set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G4029	Preventive medicine mips specialty set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G4030	Pulmonology mips specialty set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G4031	Radiation oncology mips specialty set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G4032	Rheumatology mips specialty set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G4033	Skilled nursing facility mips specialty set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G4034	Speech language pathology mips specialty set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G4035	Thoracic surgery mips specialty set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G4036	Urgent care mips specialty set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G4037	Urology mips specialty set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G4038	Vascular surgery mips specialty set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8395	LVEF>=40% doc normal or mild	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8396	LVEF not performed	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8397	Dil macula/fundus exam/w doc	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8399	Pt w/dxa results document	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8400	Pt w/dxa no results doc	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8404	Low extemity neur exam docum	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8405	Low extemity 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.	–	–	–
G8427	Docrev cur meds by elig clin	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8428	Cur meds not document	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8430	Doc med rsn no medrec	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8431	Pos clin depres scrn f/u doc	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8432	Dep scr not doc rng	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8433	Scr for dep not cpt doc rsn	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8450	Beta-bloc rx pt w/abn lvef	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8451	Pt w/abn lvef inelig b-bloc	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8452	Pt w/abn lvef b-bloc no rx	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8465	High risk recurrence pro ca	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8473	ACE/ARB thxpy rx?d	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8474	Ace/arb not rx'd; doc reas	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8475	ACE/ARB thxpy not rx?d	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8476	Bp sys <140 and dias <90	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8477	Bp sys>=140 and/or dias >=90	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8478	BP not performed/doc	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8482	Flu immunize order/admin	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8483	Flu imm no admin doc rea	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8484	Flu immunize no admin	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8506	PATIENT RECEIVING ANGIOTENSIN CONVERTING ENZYME (ACE) INHIBITOR OR ANGIOTENSIN RECEPTOR BLOCKER (ARB) THERAPY	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8510	Screening for depression is documented as negative a follow-up plan is not required	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8511	Screening for depression documented as positive follow-up plan not documented reason not given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G8535	Elder maltreatment screen not documented; documentation that patient is not eligible for the elder maltreatment screen at the time of the encounter	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8536	No documentation of an elder maltreatment screen reason not given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8539	Functional outcome assessment documented as positive using a standardized tool and a care plan based on identified deficiencies is documented within two days of the functional outcome assessment	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8540	Functional outcome assessment not documented as being performed documentation the patient is not eligible for a functional outcome assessment using a standardized tool at the time of the encounter	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8541	Functional outcome assessment using a standardized tool not documented reason not given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8542	Functional outcome assessment using a standardized tool is documented; no functional deficiencies identified care plan not required	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8543	Documentation of a positive functional outcome assessment using a standardized tool; care plan not documented within two days of assessment reason not given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8559	Pt ref doc oto eval	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8560	Pt hx act drain prev 90 days	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8561	Pt inelig for ref oto eval	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8562	Pt no hx act drain 90 d	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8563	Pt no ref oto reas no spec	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8564	Pt ref oto eval	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8565	Ver doc hear loss	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8566	Pt inelig ref oto eval	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8567	Pt no doc hear loss	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G8568	Pt no ref otolo no spec	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8569	Prol intubation req	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8570	No prol intub req	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8575	Postop ren fail	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8576	No postop ren fail	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8577	Reop req bld grft oth	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8578	No reop req bld grft oth	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8598	Asa/antiplat ther used	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8599	No asa/antiplat ther use rng	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8600	Tpa initi w/in 4.5 hr	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8601	No elig tpa init w/in 4.5 hr	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8602	No tpa init w/in 4.5 hr	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8633	Pharmacologic therapy (other than minerals/vitamins) for osteoporosis prescribed	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8635	Pharmacologic therapy for osteoporosis was not prescribed reason not given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8647	Residual score for the knee impairment successfully calculated and the score was equal to zero (0) or greater than zero (> 0)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8648	Residual score for the knee impairment successfully calculated and the score was less than zero (< 0)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8650	Residual score for the knee impairment not measured because the patient did not complete the lepf prom at initial evaluation and/or near discharge reason not given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8651	Residual score for the hip impairment successfully calculated and the score was equal to zero (0) or greater than zero (> 0)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8652	Residual score for the hip impairment successfully calculated and the score was less than zero (< 0)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G8654	Residual score for the hip impairment not measured because the patient did not complete the lepf prom at initial evaluation and/or near discharge reason not given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8655	Residual score for the lower leg foot or ankle impairment successfully calculated and the score was equal to zero (0) or greater than zero (> 0)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8656	Residual score for the lower leg foot or ankle impairment successfully calculated and the score was less than zero (< 0)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8658	Residual score for the lower leg foot or ankle impairment not measured because the patient did not complete the lepf prom at initial evaluation and/or near discharge reason not given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8659	Residual score for the low back impairment successfully calculated and the score was equal to zero (0) or greater than zero (> 0)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8660	Residual score for the low back impairment successfully calculated and the score was less than zero (< 0)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8661	Risk-adjusted functional status change residual score for the low back impairment not measured because the patient did not complete the fs status survey near discharge patient not appropriate	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8662	Residual score for the low back impairment not measured because the patient did not complete the low back fs prom at initial evaluation and/or near discharge reason not given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8663	Residual score for the shoulder impairment successfully calculated and the score was equal to zero (0) or greater than zero (> 0)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8664	Residual score for the shoulder impairment successfully calculated and the score was less than zero (< 0)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G8666	Residual score for the shoulder impairment not measured because the patient did not complete the shoulder fs prom at initial evaluation and/or near discharge reason not given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8667	Residual score for the elbow wrist or hand impairment successfully calculated and the score was equal to zero (0) or greater than zero (> 0)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8668	Residual score for the elbow wrist or hand impairment successfully calculated and the score was less than zero (< 0)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8670	Residual score for the elbow wrist or hand impairment not measured because the patient did not complete the elbow/wrist/hand fs prom at initial evaluation and/or near discharge reason not given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8694	Left ventricular ejection fraction (lvef) < = 40% or documentation of moderate or severe lvsd	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8708	Patient not prescribed antibiotic	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8709	Uri episodes when the patient had competing diagnoses on or three days after the episode date (e.g. intestinal infection pertussis bacterial infection lyme disease otitis media acute sinusitis acute pharyngitis acute tonsillitis chronic sinusitis infection of the pharynx/larynx/tonsils/adenoids prostatitis cellulitis mastoiditis or bone infections acute lymphadenitis impetigo skin staph infections pneumonia/gonococcal infections venereal disease (syphilis chlamydia inflammatory diseases [female reproductive organs]) infections of the kidney cystitis or uti and acne)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8710	Patient prescribed antibiotic	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8711	Prescribed antibiotic on or within 3 days after the episode date	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8712	ANTIBIOTIC NOT PRESCRIBED OR DISPENSED	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G8721	PT CATEGORY (PRIMARY TUMOR) PN CATEGORY (REGIONAL LYMPH NODES) AND HISTOLOGIC GRADE WERE DOCUMENTED IN PATHOLOGY REPORT	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8722	Documentation of medical reason(s) for not including the pt category the pn category or the histologic grade in the pathology report (e.g. re-excision without residual tumor; non-carcinomasanal canal)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8723	SPECIMEN SITE IS OTHER THAN ANATOMIC LOCATION OF PRIMARY TUMOR	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8724	Pt category pn category and histologic grade were not documented in the pathology report reason not given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8733	Elder maltreatment screen documented as positive and a follow-up plan is documented	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8734	Elder maltreatment screen documented as negative follow-up is not required	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8735	Elder maltreatment screen documented as positive follow-up plan not documented reason not given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8749	Absence of signs of melanoma (tenderness jaundice localized neurologic signs such as weakness or any other sign suggesting systemic spread) or absence of symptoms of melanoma (cough dyspnea pain paresthesia or any other symptom suggesting the possibility of systemic spread of melanoma)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8752	MOST RECENT SYSTOLIC BLOOD PRESSURE < 140MMHG	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8753	MOST RECENT SYSTOLIC BLOOD PRESSURE >= 140MMHG	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8754	MOST RECENT DIASTOLIC BLOOD PRESSURE < 90MMHG	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8755	MOST RECENT DIASTOLIC BLOOD PRESSURE >= 90MMHG	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8756	No documentation of blood pressure measurement reason not given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8783	Normal blood pressure reading documented follow-up not required	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G8785	Blood pressure reading not documented reason not given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8797	SPECIMEN SITE OTHER THAN ANATOMIC LOCATION OF ESOPHAGUS	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8798	SPECIMEN SITE OTHER THAN ANATOMIC LOCATION OF PROSTATE	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8806	Performance of trans-abdominal or trans-vaginal ultrasound and pregnancy location documented	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8807	Trans-abdominal or trans-vaginal ultrasound not performed for reasons documented by clinician (e.g. patient has visited the ed multiple times within 72 hours patient has a documented intrauterine pregnancy [iup])	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8808	Trans-abdominal or trans-vaginal ultrasound not performed reason not given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8815	Documented reason in the medical records for why the statin therapy was not prescribed (i.e. lower extremity bypass was for a patient with non-artherosclerotic disease)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8816	STATIN MEDICATION PRESCRIBED AT DISCHARGE	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8817	Statin therapy not prescribed at discharge reason not given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8818	PATIENT DISCHARGE TO HOME NO LATER THAN POST-OPERATIVE DAY #7	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8825	PATIENT NOT DISCHARGED TO HOME BY POST-OPERATIVE DAY #7	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8826	Patient discharged to home no later than post-operative day #2 following evar	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8833	Patient not discharged to home by post-operative day #2 following evar	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8834	PATIENT DISCHARGED TO HOME NO LATER THAN POST-OPERATIVE DAY #2 FOLLOWING CEA	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8838	Patient not discharged to home by post-operative day #2 following cea	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8839	SLEEP APNEA SYMPTOMS ASSESSED INCLUDING PRESENCE OR ABSENCE OF SNORING AND DAYTIME SLEEPINESS	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G8840	Documentation of reason(s) for not documenting an assessment of sleep symptoms (e.g. patient didn't have initial daytime sleepiness patient visited between initial testing and initiation of therapy)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8841	Sleep apnea symptoms not assessed reason not given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8842	Apnea hypopnea index (ahi) respiratory disturbance index (rdi) or respiratory event index (rei) documented or measured within 2 months of initial evaluation for suspected obstructive sleep apnea	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8843	Documentation of reason(s) for not measuring an apnea hypopnea index (ahi) a respiratory disturbance index (rdi) or a respiratory event index (rei) within 2 months of initial evaluation for suspected obstructive sleep apnea (e.g. medical neurological or psychiatric disease that prohibits successful completion of a sleep study patients for whom a sleep study would present a bigger risk than benefit or would pose an undue burden dementia patients who decline ahi/rdi/rei measurement patients who had a financial reason for not completing testing test was ordered but not completed patients decline because their insurance (payer) does not cover the expense))	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8844	Apnea hypopnea index (ahi) respiratory disturbance index (rdi) or respiratory event index (rei) not documented or measured within 2 months of initial evaluation for suspected obstructive sleep apnea reason not given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8845	POSITIVE AIRWAY PRESSURE THERAPY PRESCRIBED	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8846	MODERATE OR SEVERE OBSTRUCTIVE SLEEP APNEA (APNEA HYPOPNEA INDEX (AHI) OR RESPIRATORY DISTURBANCE INDEX (RDI) OF 15 OR GREATER)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G8849	Documentation of reason(s) for not prescribing positive airway pressure therapy (e. G. patient unable to tolerate alternative therapies use patient declined financial insurance coverage)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8850	Positive airway pressure therapy not prescribed reason not given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8851	OBJECTIVE MEASUREMENT OF ADHERENCE TO POSITIVE AIRWAY PRESSURE THERAPY DOCUMENTED	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8852	Positive airway pressure therapy was prescribed	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8854	Documentation of reason(s) for not objectively measuring adherence to positive airway pressure therapy (e.g. patient didn't bring data from continuous positive airway pressure [cpap] therapy not yet initiated not available on machine)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8855	Objective measurement of adherence to positive airway pressure therapy not performed reason not given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8856	REFERRAL TO A PHYSICIAN FOR AN OTOLOGIC EVALUATION PERFORMED	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8857	PATIENT IS NOT ELIGIBLE FOR THE REFERRAL FOR OTOLOGIC EVALUATION MEASURE (E.G. PATIENTS WHO ARE ALREADY UNDER THE CARE OF A PHYSICIAN FOR ACUTE OR CHRONIC DIZZINESS)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8858	Referral to a physician for an otologic evaluation not performed reason not given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8863	Patients not assessed for risk of bone loss reason not given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8864	PNEUMOCOCCAL VACCINE ADMINISTERED OR PREVIOUSLY RECEIVED	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8865	DOCUMENTATION OF MEDICAL REASON(S) FOR NOT ADMINISTERING OR PREVIOUSLY RECEIVING PNEUMOCOCCAL VACCINE (E.G. PATIENT ALLERGIC REACTION POTENTIAL ADVERSE DRUG REACTION)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8866	DOCUMENTATION OF PATIENT REASON(S) FOR NOT ADMINISTERING OR PREVIOUSLY RECEIVING PNEUMOCOCCAL VACCINE (E.G. PATIENT REFUSAL)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G8867	Pneumococcal vaccine not administered or previously received reason not given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8869	Patient has documented immunity to hepatitis b and initiating anti-tnf therapy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8875	CLINICIAN DIAGNOSED BREAST CANCER PREOPERATIVELY BY A MINIMALLY INVASIVE BIOPSY METHOD	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8876	Documentation of reason(s) for not performing minimally invasive biopsy to diagnose breast cancer properatively (e.g. lesion too close to skin implant chest wall etc. lesion could not be adequately visualized for needle biopsy patient condition prevents needle biopsy [weight breast thickness etc.] duct excision without imaging abnormality prophylactic mastectomy reduction mammoplasty excisional biopsy performed by another physician)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8877	Clinician did not attempt to achieve the diagnosis of breast cancer preoperatively by a minimally invasive biopsy method reason not given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8878	SENTINEL LYMPH NODE BIOPSY PROCEDURE PERFORMED	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8880	Documentation of reason(s) sentinel lymph node biopsy not performed (e.g. reasons could include but not limited to; non-invasive cancer incidental discovery of breast cancer on prophylactic mastectomy incidental discovery of breast cancer on reduction mammoplasty pre-operative biopsy proven lymph node (ln) metastases inflammatory carcinoma stage 3 locally advanced cancer recurrent invasive breast cancer clinically node positive after neoadjuvant systemic therapy patient refusal after informed consent patient with significant age comorbidities or limited life expectancy and favorable tumor; adjuvant systemic therapy unlikely to change)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G8881	STAGE OF BREAST CANCER IS GREATER THAN T1N0M0 OR T2N0M0	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8882	Sentinel lymph node biopsy procedure not performed reason not given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8883	BIOPSY RESULTS REVIEWED COMMUNICATED TRACKED AND DOCUMENTED	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8884	CLINICIAN DOCUMENTED REASON THAT PATIENT'S BIOPSY RESULTS WERE NOT REVIEWED	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8885	BIPSY RESULTS NOT REVIEWED COMMUNICATED TRACKED OR DOCUMENTED	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8907	Patient documented not to have experienced any of the following events: a burn prior to discharge a fall within the facility wrong site/side/patient/procedure/implant event a hospital transfer or hospital admission upon discharge from the facility.	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8908	Patient documented to have received a burn prior to discharge	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8909	Patient documented not to have received a burn prior to discharge	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8910	Patient documented to have experienced a fall within ASC	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8911	Patient documented not to have experienced a fall within ASC	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8912	Patient documented to have experienced a wrong site wrong side wrong patient wrong procedure or wrong implant event	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8913	Patient documented not to have experienced a wrong site wrong side wrong patient wrong procedure or wrong implant event	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8914	Patient documented to have experienced a hospital transfer or hospital admission upon discharge from ASC	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8915	Patient documented not to have experienced a hospital transfer or hospital admission upon discharge from ASC	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8916	Patient with preoperative order for IV antibiotic surgical site infection. (SSI) prophylaxis antibiotic initiated on time.	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G8917	Patient with preoperative order for IV antibiotic surgical site infection. (SSI) prophylaxis antibiotic not initiated on time.	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8918	Patient without preoperative order for IV antibiotic surgical site infection. (SSI) prophylaxis	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8923	Left ventricular ejection fraction (lvef) <= 40% or documentation of moderately or severely depressed left ventricular systolic function	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8924	Spirometry test results demonstrate fev1/fvc < 70% fev1 < 60% predicted and patient has copd symptoms (e.g. dyspnea cough/sputum wheezing)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8934	Left ventricular ejection fraction (lvef) <=40% or documentation of moderately or severely depressed left ventricular systolic function	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8935	Clinician prescribed angiotensin converting enzyme (ace) inhibitor or angiotensin receptor blocker (arb) therapy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8936	Clinician documented that patient was not an eligible candidate for angiotensin converting enzyme (ace) inhibitor or angiotensin receptor blocker (arb) therapy (eg allergy intolerance pregnancy renal failure due to ace inhibitor diseases of the aortic or mitral valve other medical reasons) or (eg patient declined other patient reasons) or (eg lack of drug availability other reasons attributable to the health care system)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8937	Clinician did not prescribe angiotensin converting enzyme (ace) inhibitor or angiotensin receptor blocker (arb) therapy reason not given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8941	Elder maltreatment screen documented as positive follow-up plan not documented documentation the patient is not eligible for follow-up plan at the time of the encounter	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G8942	Functional outcomes assessment using a standardized tool is documented within the previous 30 days and care plan based on identified deficiencies is documented within two days of the functional outcome assessment	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8944	Ajcc melanoma cancer stage 0 through iic melanoma	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8946	Minimally invasive biopsy method attempted but not diagnostic of breast cancer (e.g. high risk lesion of breast such as atypical ductal hyperplasia lobular neoplasia atypical lobular hyperplasia lobular carcinoma in situ atypical columnar hyperplasica flat epithelial atypia radial scar complex sclerosing lesion papillary lesion or any lesion with spindle cells)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8950	Elevated or hypertensive blood pressure reading documented and the indicated follow-up is documented	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8952	Elevated or hypertensive blood pressure reading documented indicated follow-up not documented reason not given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8955	Most recent assessment of adequacy of volume management documented	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8956	Patient receiving maintenance hemodialysis in an outpatient dialysis facility	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8958	Assessment of adequacy of volume management not documented reason not given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8961	Cardiac stress imaging test primarily performed on low-risk surgery patient for preoperative evaluation within 30 days preceding this surgery	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8962	Cardiac stress imaging test performed on patient for any reason including those who did not have low risk surgery or test that was performed more than 30 days preceding low risk surgery	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G8963	Cardiac stress imaging performed primarily for monitoring of asymptomatic patient who had pci wihin 2 years	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8964	Cardiac stress imaging test performed primarily for any other reason than monitoring of asymptomatic patient who had pci wthin 2 years (e. G. symptomatic patient patient greater than 2 years since pci initial evaluation etc)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8965	Cardiac stress imaging test primarily performed on low chd risk patient for initial detection and risk assessment	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8966	Cardiac stress imaging test performed on symptomatic or higher than low chd risk patient or for any reason other than initial detection and risk assessment	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8967	Fda approved oral anticoagulant is prescribed	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8968	Documentation of medical reason(s) for not prescribing an fda-approved anticoagulant (e.g. present or planned atrial appendage occlusion or ligation)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8969	Documentation of patient reason(s) for not prescribing an oral anticoagulant that is fda approved for the prevention of thromboembolism (e.g. patient preference for not receiving anticoagulation)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8970	No risk factors or one moderate risk factor for thromboembolism	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.	–	–	–
G9013	ESRD DEMO BASIC BUNDLE LEVEL I	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9014	ESRD DEMO EXPANDED BUNDLE INCLUDING VENOUS ACCESS AND RELATED SERVICES	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9016	Smoking cessation counseling individual in the absence of or in addition to any other evaluation and management service per session (6-10 minutes) [demo project code only]	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service 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: Procedure/service 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.	–	–	–
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 stgI no progres	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9064	Onc dx nsclc stg2 no progres	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9065	Onc dx nsclc stg3A no progre	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9066	Onc dx nsclc stg3B-4 metasta	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9067	Onc dx nsclc dx unknown nos	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service 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 metastic/ recur	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9077	Onc dx prostate T1no progres	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9078	Onc dx prostate T2no progres	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9079	Onc dx prostate T3b-T4noprog	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service 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.	–	–	–
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.	–	–	–
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.	–	–	–
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.	–	–	–
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).	–	–	–
G9148	National Committee for Quality Assurance - Level I medical home	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9149	National Committee for Quality Assurance - Level II medical home	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G9150	National Committee for Quality Assurance - Level III medical home	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9151	Multi-payer Advanced Primary Care Practice Demonstration State	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9152	Multi-payer Advanced Primary Care Practice Demonstration Community	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9153	Multi-payer Advanced Primary Care Practice Demonstration Physician	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9187	Bundled Payments for Care Improvement Initiative home visit for patient assessment performed by a qualified health care professional for individuals not considered homebound including but not limited to assessment of safety falls clinical status fluid status medication reconciliation/management patient compliance with orders/plan of care performance of activities of daily living appropriateness of care setting. (For use only in the Medicare-approved Bundled Payments for Care Improvement Initiative.) May not be billed for a 30-day period covered by a transitional care management code	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9188	Beta-blocker therapy not prescribed reason not given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9189	Beta-blocker therapy prescribed or currently being taken	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9190	Documentation of medical reason(s) for not prescribing beta-blocker therapy (eg allergy intolerance other medical reasons)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9191	Documentation of patient reason(s) for not prescribing beta-blocker therapy (eg patient declined other patient reasons)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9192	Documentation of system reason(s) for not prescribing beta-blocker therapy (eg other reasons attributable to the health care system)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9212	Dsm-ivtm criteria for major depressive disorder documented at the initial evaluation	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G9213	Dsm-iv-tr criteria for major depressive disorder not documented at the initial evaluation reason not otherwise specified	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9223	Pneumocystis jiroveci pneumonia prophylaxis prescribed within 3 months of low cd4+ cell count below 500 cells/mm3 or a cd4 percentage below 15%	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9225	Foot exam was not performed reason not given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9226	Foot examination performed (includes examination through visual inspection sensory exam with 10-g monofilament plus testing any one of the following: vibration using 128-hz tuning fork pinprick sensation ankle reflexes or vibration perception threshold and pulse exam; report when all of the 3 components are completed)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9227	Functional outcome assessment documented care plan not documented documentation the patient is not eligible for a care plan at the time of the encounter	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9228	Chlamydia gonorrhea and syphilis screening results documented (report when results are present for all of the 3 screenings)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9229	Chlamydia gonorrhea and syphilis screening results not documented (patient refusal is the only allowed exception)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9230	Chlamydia gonorrhea and syphilis not screened reason not given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9231	Documentation of end stage renal disease (esrd) dialysis renal transplant before or during the measurement period or pregnancy during the measurement period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9242	Documentation of viral load equal to or greater than 200 copies/ml or viral load not performed	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9243	Documentation of viral load less than 200 copies/ml	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G9246	Patient did not have at least one medical visit in each 6 month period of the 24 month measurement period with a minimum of 60 days between medical visits	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9247	Patient had at least one medical visit in each 6 month period of the 24 month measurement period with a minimum of 60 days between medical visits	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9254	Documentation of patient discharged to home later than post-operative day 2 following cas	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9255	Documentation of patient discharged to home no later than post operative day 2 following cas	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9273	Blood pressure has a systolic value of < 140 and a diastolic value of < 90	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9274	Blood pressure has a systolic value of =140 and a diastolic value of = 90 or systolic value < 140 and diastolic value = 90 or systolic value = 140 and diastolic value < 90	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9275	Documentation that patient is a current non-tobacco user	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9276	Documentation that patient is a current tobacco user	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9277	Documentation that the patient is on daily aspirin or anti-platelet or has documentation of a valid contraindication or exception to aspirin/anti-platelet; contraindications/exceptions include anti-coagulant use allergy to aspirin or anti-platelets history of gastrointestinal bleed and bleeding disorder; additionally the following exceptions documented by the physician as a reason for not taking daily aspirin or anti-platelet are acceptable (use of non-steroidal anti-inflammatory agents documented risk for drug interaction uncontrolled hypertension defined as >180 systolic or >110 diastolic or gastroesophageal reflux)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9278	Documentation that the patient is not on daily aspirin or anti-platelet regimen	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G9279	Pneumococcal screening performed and documentation of vaccination received prior to discharge	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9280	Pneumococcal vaccination not administered prior to discharge reason not specified	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9281	Screening performed and documentation that vaccination not indicated/patient refusal	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9282	Documentation of medical reason(s) for not reporting the histological type or nsclc-nos classification with an explanation (e.g. biopsy taken for other purposes in a patient with a history of non-small cell lung cancer or other documented medical reasons)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9283	Non small cell lung cancer biopsy and cytology specimen report documents classification into specific histologic type or classified as nsclc-nos with an explanation	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9284	Non small cell lung cancer biopsy and cytology specimen report does not document classification into specific histologic type or classified as nsclc-nos with an explanation	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9285	Specimen site other than anatomic location of lung or is not classified as non small cell lung cancer	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9286	Antibiotic regimen prescribed within10 days after onset of symptoms	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9287	Antibiotic regimen not prescribed within 10 days after onset of symptoms	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9288	Documentation of medical reason(s) for not reporting the histological type or nsclc-nos classification with an explanation (e.g. a solitary fibrous tumor in a person with a history of non-small cell carcinoma or other documented medical reasons)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G9289	Non small cell lung cancer biopsy and cytology specimen report documents classification into specific histologic type or classified as nsclc-nos with an explanation	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9290	Non small cell lung cancer biopsy and cytology specimen report does not document classification into specific histologic type or classified as nsclc-nos with an explanation	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9291	Specimen site other than anatomic location of lung is not classified as non small cell lung cancer or classified as nsclc-nos	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9292	Documentation of medical reason(s) for not reporting pt category and a statement on thickness and ulceration and for pt1 mitotic rate (e.g. negative skin biopsies in a patient with a history of melanoma or other documented medical reasons)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9293	Pathology report does not include the pt category and a statement on thickness and ulceration and for pt1 mitotic rate	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9294	Pathology report includes the pt category and a statement on thickness and ulceration and for pt1 mitotic rate	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9295	Specimen site other than anatomic cutaneous location	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9296	Patients with documented shared decision-making including discussion of conservative (non-surgical) therapy (e.g. nsaids analgesics weight loss exercise injections) prior to the procedure	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9297	Shared decision-making including discussion of conservative (non-surgical) therapy (e.g. nsaids analgesics weight loss exercise injections) prior to the procedure not documented reason not given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G9298	Patients who are evaluated for venous thromboembolic and cardiovascular risk factors within 30 days prior to the procedure (e.g. history of dvt pe mi arrhythmia and stroke)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre· service review.	–	–	–
G9299	Patients who are not evaluated for venous thromboembolic and cardiovascular risk factors within 30 days prior to the procedure (e.g. history of dvt pe mi arrhythmia and stroke reason not given)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre· service review.	–	–	–
G9305	Intervention for presence of leak of endoluminal contents through an anastomosis not required	Non Covered: Procedure/service not covered by the Plan. Not subject to pre· service review.	–	–	–
G9306	Intervention for presence of leak of endoluminal contents through an anastomosis required	Non Covered: Procedure/service not covered by the Plan. Not subject to pre· service review.	–	–	–
G9307	No return to the operating room for a surgical procedure for complications of the principal operative procedure within 30 days of the principal operative procedure	Non Covered: Procedure/service not covered by the Plan. Not subject to pre· service review.	–	–	–
G9308	Unplanned return to the operating room for a surgical procedure for complications of the principal operative procedure within 30 days of the principal operative procedure	Non Covered: Procedure/service not covered by the Plan. Not subject to pre· service review.	–	–	–
G9309	No unplanned hospital readmission within 30 days of principal procedure	Non Covered: Procedure/service not covered by the Plan. Not subject to pre· service review.	–	–	–
G9310	Unplanned hospital readmission within 30 days of principal procedure	Non Covered: Procedure/service not covered by the Plan. Not subject to pre· service review.	–	–	–
G9311	No surgical site infection	Non Covered: Procedure/service not covered by the Plan. Not subject to pre· service review.	–	–	–
G9312	Surgical site infection	Non Covered: Procedure/service not covered by the Plan. Not subject to pre· service review.	–	–	–
G9313	Amoxicillin with or without clavulanate not prescribed as first line antibiotic at the time of diagnosis for documented reason	Non Covered: Procedure/service not covered by the Plan. Not subject to pre· service review.	–	–	–
G9314	Amoxicillin with or without clavulanate not prescribed as first line antibiotic at the time of diagnosis reason not given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre· service review.	–	–	–
G9315	Amoxicillin with or without clavulanate prescribed as a first line antibiotic at the time of diagnosis	Non Covered: Procedure/service not covered by the Plan. Not subject to pre· service review.	–	–	–

G9316	Documentation of patient-specific risk assessment with a risk calculator based on multi-institutional clinical data the specific risk calculator used and communication of risk assessment from risk calculator with the patient or family	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9317	Documentation of patient-specific risk assessment with a risk calculator based on multi-institutional clinical data the specific risk calculator used and communication of risk assessment from risk calculator with the patient or family not completed	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9318	Imaging study named according to standardized nomenclature	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9319	Imaging study not named according to standardized nomenclature reason not given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9321	Count of previous ct (any type of ct) and cardiac nuclear medicine (myocardial perfusion) studies documented in the 12-month period prior to the current study	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9322	Count of previous ct and cardiac nuclear medicine (myocardial perfusion) studies not documented in the 12-month period prior to the current study reason not given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9341	Search conducted for prior patient ct studies completed at non-affiliated external healthcare facilities or entities within the past 12-months and are available through a secure authorized media-free shared archive prior to an imaging study being performed	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9342	Search not conducted prior to an imaging study being performed for prior patient ct studies completed at non-affiliated external healthcare facilities or entities within the past 12-months and are available through a secure authorized media-free shared archive reason not given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G9344	Due to system reasons search not conducted for dicom format images for prior patient ct imaging studies completed at non-affiliated external healthcare facilities or entities within the past 12 months that are available through a secure authorized media-free shared archive (e.g. non-affiliated external healthcare facilities or entities does not have archival abilities through a shared archival system)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9345	Follow-up recommendations documented according to recommended guidelines for incidentally detected pulmonary nodules (e.g. follow-up ct imaging studies needed or that no follow-up is needed) based at a minimum on nodule size and patient risk factors	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9347	Follow-up recommendations not documented according to recommended guidelines for incidentally detected pulmonary nodules reason not given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9351	More than one ct scan of the paranasal sinuses ordered or received within 90 days after diagnosis	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9352	More than one ct scan of the paranasal sinuses ordered or received within 90 days after the date of diagnosis reason not given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9353	More than one ct scan of the paranasal sinuses ordered or received within 90 days after the date of diagnosis for documented reasons (eg patients with complications second ct obtained prior to surgery other medical reasons)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9354	One ct scan or no ct scan of the paranasal sinuses ordered within 90 days after the date of diagnosis	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9355	Elective delivery (without medical indication) by cesarean birth or induction of labor not performed (<39 weeks of gestation)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G9356	Elective delivery (without medical indication) by cesarean birth or induction of labor performed (<39 weeks of gestation)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9357	Post-partum screenings evaluations and education performed	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9358	Post-partum screenings evaluations and education not performed	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9361	Medical indication for delivery by cesarean birth or induction of labor (<39 weeks of gestation) [documentation of reason(s) for elective delivery (e.g. hemorrhage and placental complications hypertension preeclampsia and eclampsia rupture of membranes (premature or prolonged) maternal conditions complicating pregnancy/delivery fetal conditions complicating pregnancy/delivery late pregnancy prior uterine surgery or participation in clinical trial)]	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9364	Sinusitis caused by or presumed to be caused by bacterial infection	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9367	At least two orders for high-risk medications from the same drug class	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9368	At least two orders for high-risk medications from the same drug class not ordered	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9380	Patient offered assistance with end of life issues during the measurement period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9382	Patient not offered assistance with end of life issues during the measurement period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9383	Patient received screening for hcv infection within the 12 month reporting period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9384	Documentation of medical reason(s) for not receiving annual screening for hcv infection (e.g. decompensated cirrhosis indicating advanced disease [i.e. ascites esophageal variceal bleeding hepatic encephalopathy] hepatocellular carcinoma waitlist for organ transplant limited life expectancy other medical reasons)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G9385	Documentation of patient reason(s) for not receiving annual screening for hcv infection (e.g. patient declined other patient reasons)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9386	Screening for hcv infection not received within the 12 month reporting period reason not given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9393	Patient with an initial phq-9 score greater than nine who achieves remission at twelve months as demonstrated by a twelve month (+/- 30 days) phq-9 score of less than five	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9394	Patient who had a diagnosis of bipolar disorder or personality disorder death permanent nursing home resident or receiving hospice or palliative care any time during the measurement or assessment period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9395	Patient with an initial phq-9 score greater than nine who did not achieve remission at twelve months as demonstrated by a twelve month (+/- 30 days) phq-9 score greater than or equal to five	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9396	Patient with an initial phq-9 score greater than nine who was not assessed for remission at twelve months (+/- 30 days)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9402	Patient received follow-up within 30 days after discharge	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9403	Clinician documented reason patient was not able to complete 30 day follow-up from acute inpatient setting discharge (e.g. patient death prior to follow-up visit patient non-compliant for visit follow-up)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9404	Patient did not receive follow-up within 30 days after discharge	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9405	Patient received follow-up within 7 days after discharge	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9406	Clinician documented reason patient was not able to complete 7 day follow-up from acute inpatient setting discharge (i.e patient death prior to follow-up visit patient non-compliance for visit follow-up)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G9407	Patient did not receive follow-up within 7 days after discharge	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9408	Patients with cardiac tamponade and/or pericardiocentesis occurring within 30 days	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9409	Patients without cardiac tamponade and/or pericardiocentesis occurring within 30 days	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9410	Patient admitted within 180 days status post cied implantation replacement or revision with an infection requiring device removal or surgical revision	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9411	Patient not admitted within 180 days status post cied implantation replacement or revision with an infection requiring device removal or surgical revision	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9412	Patient admitted within 180 days status post cied implantation replacement or revision with an infection requiring device removal or surgical revision	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9413	Patient not admitted within 180 days status post cied implantation replacement or revision with an infection requiring device removal or surgical revision	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9414	Patient had one dose of meningococcal vaccine (serogroups a c w y) on or between the patient's 11th and 13th birthdays	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9415	Patient did not have one dose of meningococcal vaccine (serogroups a c w y) on or between the patient's 11th and 13th birthdays	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9416	Patient had one tetanus diphtheria toxoids and acellular pertussis vaccine (tdap) on or between the patient's 10th and 13th birthdays	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9417	Patient did not have one tetanus diphtheria toxoids and acellular pertussis vaccine (tdap) on or between the patient's 10th and 13th birthdays	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G9418	Primary non-small cell lung cancer lung biopsy and cytology specimen report documents classification into specific histologic type following iaslc guidance or classified as nsclc-nos with an explanation	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9419	Documentation of medical reason(s) for not including the histological type or nsclc-nos classification with an explanation (e.g. specimen insufficient or non-diagnostic specimen does not contain cancer or other documented medical reasons)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9420	Specimen site other than anatomic location of lung or is not classified as primary non-small cell lung cancer	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9421	Primary non-small cell lung cancer lung biopsy and cytology specimen report does not document classification into specific histologic type or histologic type does not follow iaslc guidance or is classified as nsclc-nos but without an explanation	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9422	Primary lung carcinoma resection report documents pt category pn category and for non-small cell lung cancer histologic type (e.g. squamous cell carcinoma adenocarcinoma and not nsclc-nos)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9423	Documentation of medical reason(s) for not reporting the histological type or nsclc-nos classification with an explanation (e.g. a solitary fibrous tumor in a person with a history of non-small cell carcinoma or other documented medical reasons)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9424	Specimen site other than anatomic location of lung is not classified as non-small cell lung cancer or classified as nsclc-nos	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9425	Primary lung carcinoma resection report does not document pt category pn category and for non-small cell lung cancer histologic type (e.g. squamous cell carcinoma adenocarcinoma)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G9426	Improvement in median time from ed arrival to initial ed oral or parenteral pain medication administration performed for ed admitted patients	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9427	Improvement in median time from ed arrival to initial ed oral or parenteral pain medication administration not performed for ed admitted patients	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9428	Pathology report includes the pt category thickness ulceration and mitotic rate peripheral and deep margin status and presence or absence of microsatellitosis for invasive tumors	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9429	Documentation of medical reason(s) for not including pt category thickness ulceration and mitotic rate peripheral and deep margin status and presence or absence of microsatellitosis for invasive tumors (e.g. negative skin biopsies insufficient tissue or other documented medical reasons)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9430	Specimen site other than anatomic cutaneous location	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9431	Pathology report does not include the pt category thickness ulceration and mitotic rate peripheral and deep margin status and presence or absence of microsatellitosis for invasive tumors	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9432	Asthma well-controlled based on the act c-act acq or ataq score and results documented	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9434	Asthma not well-controlled based on the act c-act acq or ataq score or specified asthma control tool not used reason not given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9451	Patient received one-time screening for hcv infection	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9453	Documentation of patient reason(s) for not receiving one-time screening for hcv infection (e.g. patient declined other patient reasons)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G9454	One-time screening for hcv infection not received within 12-month reporting period and no documentation of prior screening for hcv infection reason not given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9455	Patient underwent abdominal imaging with ultrasound contrast enhanced ct or contrast mri for hcc	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9456	Documentation of medical or patient reason(s) for not ordering or performing screening for hcc. medical reason: comorbid medical conditions with expected survival < 5 years hepatic decompensation and not a candidate for liver transplantation or other medical reasons; patient reasons: patient declined or other patient reasons (e.g. cost of tests time related to accessing testing equipment)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9457	Patient did not undergo abdominal imaging and did not have a documented reason for not undergoing abdominal imaging in the submission period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9458	Patient documented as tobacco user and received tobacco cessation intervention (must include at least one of the following: advice given to quit smoking or tobacco use counseling on the benefits of quitting smoking or tobacco use assistance with or referral to external smoking or tobacco cessation support programs or current enrollment in smoking or tobacco use cessation program) if identified as a tobacco user	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9459	Currently a tobacco non-user	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9460	Tobacco assessment or tobacco cessation intervention not performed reason not given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G9468	Patient not receiving corticosteroids greater than or equal to 10 mg/day of prednisone equivalents for 60 or greater consecutive days or a single prescription equating to 600mg prednisone or greater for all fills	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
G9470	Patients not receiving corticosteroids greater than or equal to 10 mg/day of prednisone equivalents for 60 or greater consecutive days or a single prescription equating to 600mg prednisone or greater for all fills	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
G9471	Within the past 2 years central dual-energy x-ray absorptiometry (dxa) not ordered or documented	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
G9473	Services performed by chaplain in the hospice setting each 15 minutes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
G9474	Services performed by dietary counselor in the hospice setting each 15 minutes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
G9475	Services performed by other counselor in the hospice setting each 15 minutes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
G9476	Services performed by volunteer in the hospice setting each 15 minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
G9477	Services performed by care coordinator in the hospice setting each 15 minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
G9478	Services performed by other qualified therapist in the hospice setting each 15 minutes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
G9479	Services performed by qualified pharmacist in the hospice setting each 15 minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
G9480	Admission to medicare care choice model program (mccm)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_

G9481	Remote in-home visit for the evaluation and management of a new patient for use only in a medicare-approved cms innovation center demonstration project which requires these 3 key components: a problem focused history; a problem focused examination; and straightforward medical decision making furnished in real time using interactive audio and video technology. counseling and coordination of care with other physicians other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. usually the presenting problem(s) are self limited or minor. typically 10 minutes are spent with the patient or family or both via real time audio and video intercommunications technology	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9482	Remote in-home visit for the evaluation and management of a new patient for use only in a medicare-approved cms innovation center demonstration project which requires these 3 key components: an expanded problem focused history; an expanded problem focused examination; straightforward medical decision making furnished in real time using interactive audio and video technology. counseling and coordination of care with other physicians other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. usually the presenting problem(s) are of low to moderate severity. typically 20 minutes are spent with the patient or family or both via real time audio and video intercommunications technology	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G9483	Remote in-home visit for the evaluation and management of a new patient for use only in a medicare-approved cms innovation center demonstration project which requires these 3 key components: a detailed history; a detailed examination; medical decision making of low complexity furnished in real time using interactive audio and video technology. counseling and coordination of care with other physicians other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. usually the presenting problem(s) are of moderate severity. typically 30 minutes are spent with the patient or family or both via real time audio and video intercommunications technology	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9484	Remote in-home visit for the evaluation and management of a new patient for use only in a medicare-approved cms innovation center demonstration project which requires these 3 key components: a comprehensive history; a comprehensive examination; medical decision making of moderate complexity furnished in real time using interactive audio and video technology. counseling and coordination of care with other physicians other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. usually the presenting problem(s) are of moderate to high severity. typically 45 minutes are spent with the patient or family or both via real time audio and video intercommunications technology	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G9485	Remote in-home visit for the evaluation and management of a new patient for use only in a medicare-approved cms innovation center demonstration project which requires these 3 key components: a comprehensive history; a comprehensive examination; medical decision making of high complexity furnished in real time using interactive audio and video technology. counseling and coordination of care with other physicians other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. usually the presenting problem(s) are of moderate to high severity. typically 60 minutes are spent with the patient or family or both via real time audio and video intercommunications technology	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9486	Remote in-home visit for the evaluation and management of an established patient for use only in a medicare-approved cms innovation center demonstration project which requires at least 2 of the following 3 key components: a problem focused history; a problem focused examination; straightforward medical decision making furnished in real time using interactive audio and video technology. counseling and coordination of care with other physicians other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. usually the presenting problem(s) are self limited or minor. typically 10 minutes are spent with the patient or family or both via real time audio and video intercommunications technology	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G9487	Remote in-home visit for the evaluation and management of an established patient for use only in a medicare-approved cms innovation center demonstration project which requires at least 2 of the following 3 key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity furnished in real time using interactive audio and video technology. counseling and coordination of care with other physicians other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. usually the presenting problem(s) are of low to moderate severity. typically 15 minutes are spent with the patient or family or both via real time audio and video intercommunications technology	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G9488	Remote in-home visit for the evaluation and management of an established patient for use only in a medicare-approved cms innovation center demonstration project which requires at least 2 of the following 3 key components: a detailed history; a detailed examination; medical decision making of moderate complexity furnished in real time using interactive audio and video technology. counseling and coordination of care with other physicians other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. usually the presenting problem(s) are of moderate to high severity. typically 25 minutes are spent with the patient or family or both via real time audio and video intercommunications technology	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9489	Remote in-home visit for the evaluation and management of an established patient for use only in a medicare-approved cms innovation center demonstration project which requires at least 2 of the following 3 key components: a comprehensive history; a comprehensive examination; medical decision making of high complexity furnished in real time using interactive audio and video technology. counseling and coordination of care with other physicians other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. usually the presenting problem(s) are of moderate to high severity. typically 40 minutes are spent with the patient or family or both via real time audio and video intercommunications technology	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G9490	CMS innovation center models home visit for patient assessment performed by clinical staff for an individual not considered homebound including but not necessarily limited to patient assessment of clinical status safety/fall prevention functional status/ambulation medication reconciliation/management compliance with orders/plan of care performance of activities of daily living and ensuring beneficiary connections to community and other services. (for use only in medicare-approved cms innovation center models); may not be billed for a 30 day period covered by a transitional care management code	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9497	Received instruction from the anesthesiologist or proxy prior to the day of surgery to abstain from smoking on the day of surgery	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9498	Antibiotic regimen prescribed	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9500	Radiation exposure indices documented in final report for procedure using fluoroscopy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9501	Radiation exposure indices not documented in final report for procedure using fluoroscopy reason not given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9502	Documentation of medical reason for not performing foot exam (i.e. patients who have had either a bilateral amputation above or below the knee or both a left and right amputation above or below the knee before or during the measurement period)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9504	Documented reason for not assessing hepatitis b virus (hbv) status (e.g. patient not initiating anti-tnf therapy patient declined) prior to initiating anti-tnf therapy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9505	Antibiotic regimen prescribed within 10 days after onset of symptoms for documented medical reason	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G9507	Documentation that the patient is on a statin medication or has documentation of a valid contraindication or exception to statin medications; contraindications/exceptions that can be defined by diagnosis codes include pregnancy during the measurement period active liver disease rhabdomyolysis end stage renal disease on dialysis and heart failure; provider documented contraindications/exceptions include breastfeeding during the measurement period woman of child-bearing age not actively taking birth control allergy to statin drug interaction (hiv protease inhibitors nefazodone cyclosporine gemfibrozil and danazol) and intolerance (with supporting documentation of trying a statin at least once within the last 5 years or diagnosis codes for myostitis or toxic myopathy related to drugs)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9508	Documentation that the patient is not on a statin medication	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9509	Adult patients 18 years of age or older with major depression or dysthymia who reached remission at twelve months as demonstrated by a twelve month (+/-60 days) phq-9 or phq-9m score of less than 5	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9510	Adult patients 18 years of age or older with major depression or dysthymia who did not reach remission at twelve months as demonstrated by a twelve month (+/-60 days) phq-9 or phq-9m score of less than 5. either phq- 9 or phq-9m score was not assessed or is greater than or equal to 5	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9511	Index event date phq-9 or phq-9m score greater than 9 documented during the twelve month denominator identification period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9512	Individual had a pdc of 0.8 or greater	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G9513	Individual did not have a pdc of 0.8 or greater	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9514	Patient required a return to the operating room within 90 days of surgery	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9515	Patient did not require a return to the operating room within 90 days of surgery	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9516	Patient achieved an improvement in visual acuity from their preoperative level within 90 days of surgery	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9517	Patient did not achieve an improvement in visual acuity from their preoperative level within 90 days of surgery reason not given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9518	Documentation of active injection drug use	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9519	Patient achieves final refraction (spherical equivalent) +/- 1.0 diopters of their planned refraction within 90 days of surgery	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9520	Patient does not achieve final refraction (spherical equivalent) +/- 1.0 diopters of their planned refraction within 90 days of surgery	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9521	Total number of emergency department visits and inpatient hospitalizations less than two in the past 12 months	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9522	Total number of emergency department visits and inpatient hospitalizations equal to or greater than two in the past 12 months or patient not screened reason not given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9529	Patient with minor blunt head trauma had an appropriate indication(s) for a head ct	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9530	Patient presented with a minor blunt head trauma and had a head ct ordered for trauma by an emergency care provider	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9531	Patient has documentation of ventricular shunt brain tumor multisystem trauma or is currently taking an antiplatelet medication including: abciximab anagrelide cangrelor cilostazol clopidogrel dipyridamole eptifibatide prasugrel ticlopidine ticagrelor tirofiban or vorapaxar	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G9533	Patient with minor blunt head trauma did not have an appropriate indication(s) for a head ct	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9537	Imaging needed as part of a clinical trial; or other clinician ordered the study	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9539	Intent for potential removal at time of placement	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9540	Patient alive 3 months post procedure	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9541	Filter removed within 3 months of placement	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9542	Documented re-assessment for the appropriateness of filter removal within 3 months of placement	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9543	Documentation of at least two attempts to reach the patient to arrange a clinical re-assessment for the appropriateness of filter removal within 3 months of placement	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9544	Patients that do not have the filter removed documented re-assessment for the appropriateness of filter removal or documentation of at least two attempts to reach the patient to arrange a clinical re-assessment for the appropriateness of filter removal within 3 months of placement	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9547	Cystic renal lesion that is simple appearing (bosniak i or ii) or adrenal lesion less than or equal to 1.0 cm or adrenal lesion greater than 1.0 cm but less than or equal to 4.0 cm classified as likely benign by unenhanced ct or washout protocol ct or mri with in- and opposed-phase sequences or other equivalent institutional imaging protocols	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9548	Final reports for imaging studies stating no follow-up imaging is recommended	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9549	Documentation of medical reason(s) that follow-up imaging is indicated (e.g. patient has lymphadenopathy signs of metastasis or an active diagnosis or history of cancer and other medical reason(s))	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G9550	Final reports for imaging studies with follow-up imaging recommended or final reports that do not include a specific recommendation of no follow-up	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9551	Final reports for imaging studies without an incidentally found lesion noted	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9552	Incidental thyroid nodule < 1.0 cm noted in report	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9553	Prior thyroid disease diagnosis	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9554	Final reports for ct cta mri or mra of the chest or neck with follow-up imaging recommended	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9555	Documentation of medical reason(s) for recommending follow up imaging (e.g. patient has multiple endocrine neoplasia patient has cervical lymphadenopathy other medical reason(s))	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9556	Final reports for ct cta mri or mra of the chest or neck with follow-up imaging not recommended	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9557	Final reports for ct cta mri or mra studies of the chest or neck without an incidentally found thyroid nodule < 1.0 cm noted or no nodule found	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9580	Door to puncture time of 90 minutes or less	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9582	Door to puncture time of greater than 90 minutes no reason given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9593	Pediatric patient with minor blunt head trauma classified as low risk according to the pecarn prediction rules	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9594	Patient presented with a minor blunt head trauma and had a head ct ordered for trauma by an emergency care provider	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9595	Patient has documentation of ventricular shunt brain tumor or coagulopathy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9596	Pediatric patient had a head ct for trauma ordered by someone other than an emergency care provider or was ordered for a reason other than trauma	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G9597	Pediatric patient with minor blunt head trauma not classified as low risk according to the pecarn prediction rules	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9598	Aortic aneurysm 5.5 - 5.9 cm maximum diameter on centerline formatted ct or minor diameter on axial formatted ct	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9599	Aortic aneurysm 6.0 cm or greater maximum diameter on centerline formatted ct or minor diameter on axial formatted ct	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9603	Patient survey score improved from baseline following treatment	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9604	Patient survey results not available	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9605	Patient survey score did not improve from baseline following treatment	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9606	Intraoperative cystoscopy performed to evaluate for lower tract injury	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9607	Documented medical reasons for not performing intraoperative cystoscopy (e.g. urethral pathology precluding cystoscopy any patient who has a congenital or acquired absence of the urethra) or in the case of patient death	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9608	Intraoperative cystoscopy not performed to evaluate for lower tract injury	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9609	Documentation of an order for anti-platelet agents	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9610	Documentation of medical reason(s) in the patient's record for not ordering anti-platelet agents	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9611	Order for anti-platelet agents was not documented in the patient's record reason not given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9612	Photodocumentation of two or more cecal landmarks to establish a complete examination	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9613	Documentation of post-surgical anatomy (e.g. right hemicolectomy ileocecal resection etc.)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9614	Photodocumentation of less than two cecal landmarks (i.e. no cecal landmarks or only one cecal landmark) to establish a complete examination	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G9621	Patient identified as an unhealthy alcohol user when screened for unhealthy alcohol use using a systematic screening method and received brief counseling	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9622	Patient not identified as an unhealthy alcohol user when screened for unhealthy alcohol use using a systematic screening method	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9624	Patient not screened for unhealthy alcohol use using a systematic screening method or patient did not receive brief counseling if identified as an unhealthy alcohol user	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9625	Patient sustained bladder injury at the time of surgery or discovered subsequently up to 30 days post-surgery	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9626	Documented medical reason for not reporting bladder injury (e.g. gynecologic or other pelvic malignancy documented concurrent surgery involving bladder pathology injury that occurs during a urinary incontinence procedure patient death from non-medical causes not related to surgery patient died during procedure without evidence of bladder injury)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9627	Patient did not sustain bladder injury at the time of surgery nor discovered subsequently up to 30 days post-surgery	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9628	Patient sustained bowel injury at the time of surgery or discovered subsequently up to 30 days post-surgery	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9629	Documented medical reasons for not reporting bowel injury (e.g. gynecologic or other pelvic malignancy documented planned (e.g. not due to an unexpected bowel injury) resection and/or re-anastomosis of bowel or patient death from non-medical causes not related to surgery patient died during procedure without evidence of bowel injury)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G9630	Patient did not sustain a bowel injury at the time of surgery nor discovered subsequently up to 30 days post-surgery	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9637	Final reports without documentation of one or more dose reduction techniques (e.g. automated exposure control adjustment of the ma and/or kv according to patient size use of iterative reconstruction technique)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9638	Final reports without documentation of one or more dose reduction techniques (e.g. automated exposure control adjustment of the ma and/or kv according to patient size use of iterative reconstruction technique)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9642	Current smoker (e.g. cigarette cigar pipe e-cigarette or marijuana)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9643	Elective surgery	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9644	Patients who abstained from smoking prior to anesthesia on the day of surgery or procedure	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9645	Patients who did not abstain from smoking prior to anesthesia on the day of surgery or procedure	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9646	Patients with 90 day mrs score of 0 to 2	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9648	Patients with 90 day mrs score greater than 2	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9649	Psoriasis assessment tool documented meeting any one of the specified benchmarks (e.g. (pga; 5-point or 6-point scale) body surface area (bsa) psoriasis area and severity index (pasi) and/or dermatology life quality index) (dlqi))	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9651	Psoriasis assessment tool documented not meeting any one of the specified benchmarks (e.g. (pga; 5-point or 6-point scale) body surface area (bsa) psoriasis area and severity index (pasi) and/or dermatology life quality index) (dlqi)) or psoriasis assessment tool not documented	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9654	Monitored anesthesia care (mac)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G9655	A transfer of care protocol or handoff tool/checklist that includes the required key handoff elements is used	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9656	Patient transferred directly from anesthetizing location to pacu or other non-icu location	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9658	A transfer of care protocol or handoff tool/checklist that includes the required key handoff elements is not used	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9659	Patients greater than or equal to 86 years of age who underwent a screening colonoscopy and did not have a history of colorectal cancer or other valid medical reason for the colonoscopy including: iron deficiency anemia lower gastrointestinal bleeding crohn's disease (i.e. regional enteritis) familial adenomatous polyposis lynch syndrome (i.e. hereditary non-polyposis colorectal cancer) inflammatory bowel disease ulcerative colitis abnormal finding of gastrointestinal tract or changes in bowel habits	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9660	Documentation of medical reason(s) for a colonoscopy performed on a patient greater than or equal to 86 years of age (e.g. iron deficiency anemia lower gastrointestinal bleeding crohn's disease (i.e. regional enteritis) familial history of adenomatous polyposis lynch syndrome (i.e. hereditary non-polyposis colorectal cancer) inflammatory bowel disease ulcerative colitis abnormal finding of gastrointestinal tract or changes in bowel habits)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9661	Patients greater than or equal to 86 years of age who received a colonoscopy for an assessment of signs/symptoms of gi tract illness and/or because the patient meets high risk criteria and/or to follow-up on previously diagnosed advanced lesions	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G9662	Previously diagnosed or have a diagnosis of clinical ascvd including ascvd procedure	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9663	Any ldl-c laboratory result >= 190 mg/dl	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9664	Patients who are currently statin therapy users or received an order (prescription) for statin therapy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9665	Patients who are not currently statin therapy users or did not receive an order (prescription) for statin therapy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9674	Patients with clinical ascvd diagnosis	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9675	Patients who have ever had a fasting or direct laboratory result of ldl-c = 190 mg/dl	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9676	Patients aged 40 to 75 years at the beginning of the measurement period with type 1 or type 2 diabetes and with an ldl-c result of 70-189 mg/dl recorded as the highest fasting or direct laboratory test result in the measurement year or during the two years prior to the beginning of the measurement period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9679	Onsite acute care treatment of a nursing facility resident with pneumonia. May only be billed oncper day per beneficiary.	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9680	Onsite acute care treatment of a nursing facility resident with CHF. May only be billed once per day per beneficiary.	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9681	Onsite acute care treatment of a resident with COPD or asthma. May only be billed once per day per beneficiary.	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9682	Onsite acute care treatment a nursing facility resident with a skin infection. May only be billed once per day per beneficiary	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9683	Facility service(s) for the onsite acute care treatment of a nursing facility resident with fluid or electrolyte disorder. (may only be billed once per day per beneficiary). this service is for a demonstration project	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9684	Onsite acute care treatment of a nursing facility resident for a UTI. May only be billed once per day per beneficiary.	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G9685	Physician service or other qualified health care professional for the evaluation and management of a beneficiary's acute change in condition in a nursing facility. this service is for a demonstration project	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9687	Hospice services provided to patient any time during the measurement period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9688	Patients using hospice services any time during the measurement period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9689	Patient admitted for performance of elective carotid intervention	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9690	Patient receiving hospice services any time during the measurement period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9691	Patient had hospice services any time during the measurement period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9692	Hospice services received by patient any time during the measurement period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9693	Patient use of hospice services any time during the measurement period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9694	Hospice services utilized by patient any time during the measurement period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9695	Long-acting inhaled bronchodilator prescribed	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9696	Documentation of medical reason(s) for not prescribing a long-acting inhaled bronchodilator	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9697	Documentation of patient reason(s) for not prescribing a long-acting inhaled bronchodilator	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9698	Documentation of system reason(s) for not prescribing a long-acting inhaled bronchodilator	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9699	Long-acting inhaled bronchodilator not prescribed reason not otherwise specified	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9700	Patients who use hospice services any time during the measurement period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9702	Patients who use hospice services any time during the measurement period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9703	Episodes where the patient is taking antibiotics (table 1) in the 30 days prior to the episode date or had an active prescription on the episode date	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G9704	Ajcc breast cancer stage i: t1 mic or t1a documented	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9705	Ajcc breast cancer stage i: t1b (tumor > 0.5 cm but <= 1 cm in greatest dimension) documented	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9706	Low (or very low) risk of recurrence prostate cancer	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9707	Patient received hospice services any time during the measurement period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9708	Women who had a bilateral mastectomy or who have a history of a bilateral mastectomy or for whom there is evidence of a right and a left unilateral mastectomy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9709	Hospice services used by patient any time during the measurement period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9710	Patient was provided hospice services any time during the measurement period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9711	Patients with a diagnosis or past history of total colectomy or colorectal cancer	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G9712	Documentation of medical reason(s) for prescribing or dispensing antibiotic (e.g. intestinal infection pertussis bacterial infection lyme disease otitis media acute sinusitis acute pharyngitis acute tonsillitis chronic sinusitis infection of the pharynx/larynx/tonsils/adenoids prostatitis cellulitis/ mastoiditis/bone infections acute lymphadenitis impetigo skin staph infections pneumonia gonococcal infections/venereal disease (syphilis chlamydia inflammatory diseases [female reproductive organs]) infections of the kidney cystitis/uti acne hiv disease/asymptomatic hiv cystic fibrosis disorders of the immune system malignancy neoplasms chronic bronchitis emphysema bronchiectasis extrinsic allergic alveolitis chronic airway obstruction chronic obstructive asthma pneumoconiosis and other lung disease due to external agents other diseases of the respiratory system and tuberculosis	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9713	Patients who use hospice services any time during the measurement period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9714	Patient is using hospice services any time during the measurement period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9715	Patients who use hospice services any time during the measurement period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9716	Bmi is documented as being outside of normal parameters follow-up plan is not completed for documented medical reason	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9717	Documentation stating the patient has had a diagnosis of depression or has had a diagnosis of bipolar disorder	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9719	Patient is not ambulatory bed ridden immobile confined to chair wheelchair bound dependent on helper pushing wheelchair independent in wheelchair or minimal help in wheelchair	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G9720	Hospice services for patient occurred any time during the measurement period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9721	Patient not ambulatory bed ridden immobile confined to chair wheelchair bound dependent on helper pushing wheelchair independent in wheelchair or minimal help in wheelchair	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9722	Documented history of renal failure or baseline serum creatinine >= 4.0 mg/dl; renal transplant recipients are not considered to have preoperative renal failure unless since transplantation the cr has been or is 4.0 or higher	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9723	Hospice services for patient received any time during the measurement period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9724	Patients who had documentation of use of anticoagulant medications overlapping the measurement year	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9725	Patients who use hospice services any time during the measurement period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9726	Patient refused to participate	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9727	Patient unable to complete the lepf prom at initial evaluation and/or discharge due to blindness illiteracy severe mental incapacity or language incompatibility and an adequate proxy is not available	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9728	Patient refused to participate	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9729	Patient unable to complete the lepf prom at initial evaluation and/or discharge due to blindness illiteracy severe mental incapacity or language incompatibility and an adequate proxy is not available	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9730	Patient refused to participate	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9731	Patient unable to complete the lepf prom at initial evaluation and/or discharge due to blindness illiteracy severe mental incapacity or language incompatibility and an adequate proxy is not available	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9732	Patient refused to participate	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G9733	Patient unable to complete the low back fs prom at initial evaluation and/or discharge due to blindness illiteracy severe mental incapacity or language incompatibility and an adequate proxy is not available	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9734	Patient refused to participate	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9735	Patient unable to complete the shoulder fs prom at initial evaluation and/or discharge due to blindness illiteracy severe mental incapacity or language incompatibility and an adequate proxy is not available	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9736	Patient refused to participate	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9737	Patient unable to complete the elbow/wrist/hand fs prom at initial evaluation and/or discharge due to blindness illiteracy severe mental incapacity or language incompatibility and an adequate proxy is not available	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9740	Hospice services given to patient any time during the measurement period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9741	Patients who use hospice services any time during the measurement period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9744	Patient not eligible due to active diagnosis of hypertension	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9745	Documented reason for not screening or recommending a follow-up for high blood pressure	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9746	Patient has mitral stenosis or prosthetic heart valves or patient has transient or reversible cause of af (e.g. pneumonia hyperthyroidism pregnancy cardiac surgery)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9751	Patient died at any time during the 24-month measurement period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9752	Emergency surgery	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G9753	Documentation of medical reason for not conducting a search for dicom format images for prior patient ct imaging studies completed at non-affiliated external healthcare facilities or entities within the past 12 months that are available through a secure authorized media-free shared archive (e.g. trauma acute myocardial infarction stroke aortic aneurysm where time is of the essence)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9754	A finding of an incidental pulmonary nodule	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9755	Documentation of medical reason(s) for not including a recommended interval and modality for follow-up or for no follow-up and source of recommendations (e.g. patients with unexplained fever immunocompromised patients who are at risk for infection)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9756	Surgical procedures that included the use of silicone oil	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9757	Surgical procedures that included the use of silicone oil	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9758	Patient in hospice at any time during the measurement period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9760	Patients who use hospice services any time during the measurement period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9761	Patients who use hospice services any time during the measurement period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9762	Patient had at least two hpv vaccines (with at least 146 days between the two) or three hpv vaccines on or between the patient's 9th and 13th birthdays	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9763	Patient did not have at least two hpv vaccines (with at least 146 days between the two) or three hpv vaccines on or between the patient's 9th and 13th birthdays	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9764	Patient has been treated with a systemic medication for psoriasis vulgaris	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G9765	Documentation that the patient declined change in medication or alternative therapies were unavailable has documented contraindications or has not been treated with a systemic medication for at least six consecutive months (e.g. experienced adverse effects or lack of efficacy with all other therapy options) in order to achieve better disease control as measured by pga bsa pasi or dlqi	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9766	Patients who are transferred from one institution to another with a known diagnosis of cva for endovascular stroke treatment	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9767	Hospitalized patients with newly diagnosed cva considered for endovascular stroke treatment	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9768	Patients who utilize hospice services any time during the measurement period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9769	Patient had a bone mineral density test in the past two years or received osteoporosis medication or therapy in the past 12 months	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9770	Peripheral nerve block (pnb)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9771	At least 1 body temperature measurement equal to or greater than 35.5 degrees celsius (or 95.9 degrees fahrenheit) achieved within the 30 minutes immediately before or the 15 minutes immediately after anesthesia end time	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9772	Documentation of medical reason(s) for not achieving at least 1 body temperature measurement equal to or greater than 35.5 degrees celsius (or 95.9 degrees fahrenheit) within the 30 minutes immediately before or the 15 minutes immediately after anesthesia end time (e.g. emergency cases intentional hypothermia etc.)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G9773	At least 1 body temperature measurement equal to or greater than 35.5 degrees celsius (or 95.9 degrees fahrenheit) not achieved within the 30 minutes immediately before or the 15 minutes immediately after anesthesia end time reason not given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9775	Patient received at least 2 prophylactic pharmacologic anti-emetic agents of different classes preoperatively and/or intraoperatively	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9776	Documentation of medical reason for not receiving at least 2 prophylactic pharmacologic anti-emetic agents of different classes preoperatively and/or intraoperatively (e.g. intolerance or other medical reason)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9777	Patient did not receive at least 2 prophylactic pharmacologic anti-emetic agents of different classes preoperatively and/or intraoperatively	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9779	Patients who are breastfeeding at any time during the measurement period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9780	Patients who have a diagnosis of rhabdomyolysis at any time during the measurement period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9781	Documentation of medical reason(s) for not currently being a statin therapy user or receiving an order (prescription) for statin therapy (e.g. patients with statin-associated muscle symptoms or an allergy to statin medication therapy patients who are receiving palliative or hospice care patients with active liver disease or hepatic disease or insufficiency patients with end stage renal disease [esrd] or other medical reasons)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9782	History of or active diagnosis of familial hypercholesterolemia	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9784	Pathologists/dermatopathologists providing a second opinion on a biopsy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G9785	Pathology report diagnosing cutaneous basal cell carcinoma squamous cell carcinoma or melanoma (to include in situ disease) sent from the pathologist/ dermatopathologist to the biopsying clinician for review within 7 days from the time when the tissue specimen was received by the pathologist	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	
G9786	Pathology report diagnosing cutaneous basal cell carcinoma squamous cell carcinoma or melanoma (to include in situ disease) was not sent from the pathologist/ dermatopathologist to the biopsying clinician for review within 7 days from the time when the tissue specimen was received by the pathologist	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	
G9787	Patient alive as of the last day of the measurement year	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	
G9788	Most recent bp is less than or equal to 140/90 mm hg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	
G9789	Blood pressure recorded during inpatient stays emergency room visits or urgent care visits	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	
G9790	Most recent bp is greater than 140/90 mm hg or blood pressure not documented	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	
G9791	Most recent tobacco status is tobacco free	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	
G9792	Most recent tobacco status is not tobacco free	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	
G9793	Patient is currently on a daily aspirin or other antiplatelet	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	
G9794	Documentation of medical reason(s) for not on a daily aspirin or other antiplatelet (e.g. history of gastrointestinal bleed intra-cranial bleed idiopathic thrombocytopenic purpura (itp) gastric bypass or documentation of active anticoagulant use during the measurement period)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	
G9795	Patient is not currently on a daily aspirin or other antiplatelet	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	
G9796	Patient is currently on a statin therapy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	
G9797	Patient is not on a statin therapy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	

G9805	Patients who use hospice services any time during the measurement period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9806	Patients who received cervical cytology or an hpv test	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9807	Patients who did not receive cervical cytology or an hpv test	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9812	Patient died including all deaths occurring during the hospitalization in which the operation was performed even if after 30 days and those deaths occurring after discharge from the hospital but within 30 days of the procedure	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9813	Patient did not die within 30 days of the procedure or during the index hospitalization	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9818	Documentation of sexual activity	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9819	Patients who use hospice services any time during the measurement period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9820	Documentation of a chlamydia screening test with proper follow-up	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9821	No documentation of a chlamydia screening test with proper follow-up	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9822	Patients who had an endometrial ablation procedure during the 12 months prior to the index date (exclusive of the index date)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9823	Endometrial sampling or hysteroscopy with biopsy and results documented during the 12 months prior to the index date (exclusive of the index date) of the endometrial ablation	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9824	Endometrial sampling or hysteroscopy with biopsy and results not documented during the 12 months prior to the index date (exclusive of the index date) of the endometrial ablation	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9830	Her-2/neu positive	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9831	Ajcc stage at breast cancer diagnosis = ii or iii	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9832	Ajcc stage at breast cancer diagnosis = i (ia or ib) and t-stage at breast cancer diagnosis does not equal = t1 t1a t1b	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G9838	Patient has metastatic disease at diagnosis	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9839	Anti-egfr monoclonal antibody therapy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9840	Ras (kras and nras) gene mutation testing performed before initiation of anti-egfr moab	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9841	Ras (kras and nras) gene mutation testing not performed before initiation of anti-egfr moab	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9842	Patient has metastatic disease at diagnosis	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9843	Ras (kras or nras) gene mutation	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9844	Patient did not receive anti-egfr monoclonal antibody therapy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9845	Patient received anti-egfr monoclonal antibody therapy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9846	Patients who died from cancer	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9847	Patient received systemic cancer-directed therapy in the last 14 days of life	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9848	Patient did not receive systemic cancer-directed therapy in the last 14 days of life	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9852	Patients who died from cancer	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9853	Patient admitted to the icu in the last 30 days of life	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9854	Patient was not admitted to the icu in the last 30 days of life	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9858	Patient enrolled in hospice	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9859	Patients who died from cancer	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9860	Patient spent less than three days in hospice care	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9861	Patient spent greater than or equal to three days in hospice care	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9862	Documentation of medical reason(s) for not recommending at least a 10 year follow-up interval (e.g. inadequate prep familial or personal history of colonic polyps patient had no adenoma and age is = 66 years old or life expectancy < 10 years old other medical reasons)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G9868	Receipt and analysis of remote asynchronous images for dermatologic and/or ophthalmologic evaluation for use only in a medicare-approved cmmi model less than 10 minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9869	Receipt and analysis of remote asynchronous images for dermatologic and/or ophthalmologic evaluation for use only in a medicare-approved cmmi model 10-20 minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9870	Receipt and analysis of remote asynchronous images for dermatologic and/or ophthalmologic evaluation for use only in a medicare-approved cmmi model more than 20 minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9873	First Medicare Diabetes Prevention Program (MDPP) core session was attended by an MDPP beneficiary under the MDPP Expanded Model (EM). A core session is an MDPP service that: (1) is furnished by an MDPP supplier during months 1 through 6 of the MDPP services period; (2) is approximately 1 hour in length; and (3)adheres to a CDC-approved DPP curriculum for core sessions	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9874	Four total Medicare Diabetes Prevention Program (MDPP) core sessions were attended by an MDPP beneficiary under the MDPP Expanded Model (EM). A core session is an MDPP service that: (1) is furnished by an MDPP supplier during months 1 through 6 of the MDPP services period; (2) is approximately 1 hour in length; and (3) adheres to a CDC-approved DPP curriculum for core sessions.	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G9875	Nine total Medicare Diabetes Prevention Program (MDPP) core sessions were attended by an MDPP beneficiary under the MDPP Expanded Model (EM). A core session is an MDPP service that: (1) is furnished by an MDPP supplier during months 1 through 6 of the MDPP services period; (2) is approximately 1 hour in length; and (3) adheres to a CDC-approved DPP curriculum for core sessions.	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9876	Two Medicare Diabetes Prevention Program (MDPP) core maintenance sessions (MS) were attended by an MDPP beneficiary in months (mo) 7-9 under the MDPP Expanded Model (EM). A core maintenance session is an MDPP service that: (1) is furnished by an MDPP supplier during months 7 through 12 of the MDPP services period; (2) is approximately 1 hour in length; and (3) adheres to a CDC-approved DPP curriculum for maintenance sessions. The beneficiary did not achieve at least 5% weight loss (WL) from his/her baseline weight as measured by at least one in-person weight measurement at a core maintenance session in months 7-9.	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9877	Two Medicare Diabetes Prevention Program (MDPP) core maintenance sessions (MS) were attended by an MDPP beneficiary in months (mo) 10-12 under the MDPP Expanded Model (EM). A core maintenance session is an MDPP service that: (1) is furnished by an MDPP supplier during months 7 through 12 of the MDPP services period; (2) is approximately 1 hour in length; and (3) adheres to a CDC-approved DPP curriculum for maintenance sessions.	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G9878	Two Medicare Diabetes Prevention Program (MDPP) core maintenance sessions (MS) were attended by an MDPP beneficiary in months (mo) 7-9 under the MDPP Expanded Model (EM). A core maintenance session is an MDPP service that: (1) is furnished by an MDPP supplier during months 7 through 12 of the MDPP services period; (2) is approximately 1 hour in length; and (3) adheres to a CDC-approved DPP curriculum for maintenance sessions.The beneficiary achieved at least 5% weight loss (WL) from his/her baseline weight as measured by at least one in-person weight measurement at a core maintenance session in months 7-9.	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9879	Two Medicare Diabetes Prevention Program (MDPP) core maintenance sessions (MS) were attended by an MDPP beneficiary in months (mo) 10-12 under the MDPP Expanded Model (EM). A core maintenance session is an MDPP service that: (1) is furnished by an MDPP supplier during months 7 through 12 of the MDPP services period; (2) is approximately 1 hour in length; and (3) adheres to a CDC-approved DPP curriculum for maintenance sessions.The beneficiary achieved at least 5% weight loss (WL) from his/her baseline weight as measured by at least one in-person weight measurement at a core maintenance session in months 10-12	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G9880	The MDPP beneficiary achieved at least 5% weight loss (WL) from his/her baseline weight in months 1-12 of the MDPP services period under the MDPP Expanded Model (EM). This is a one-time payment available when a beneficiary first achieves at least 5% weight loss from baseline as measured by an in-person weight measurement at a core session or core maintenance session.	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9881	The MDPP beneficiary achieved at least 9% weight loss (WL) from his/her baseline weight in months 1-24 under the MDPP Expanded Model (EM). This is a one-time payment available when a beneficiary first achieves at least 9% weight loss from baseline as measured by an in-person weight measurement at a core session core maintenance session or ongoing maintenance session.	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9882	Two Medicare Diabetes Prevention Program (MDPP) ongoing maintenance sessions (MS) were attended by an MDPP beneficiary in months (mo) 13-15 under the MDPP Expanded Model (EM). An ongoing maintenance session is an MDPP service that: (1) is furnished by an MDPP supplier during months 13 through 24 of the MDPP services period; (2) is approximately 1 hour in length; and (3) adheres to a CDC-approved DPP curriculum for maintenance sessions.The beneficiary maintained at least 5% weight loss (WL) from his/her baseline weight as measured by at least one in-person weight measurement at an ongoing maintenance session in months 13-15.	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G9883	Two Medicare Diabetes Prevention Program (MDPP) ongoing maintenance sessions (MS) were attended by an MDPP beneficiary in months (mo) 16-18 under the MDPP Expanded Model (EM). An ongoing maintenance session is an MDPP service that: (1) is furnished by an MDPP supplier during months 13 through 24 of the MDPP services period; (2) is approximately 1 hour in length; and (3) adheres to a CDC-approved DPP curriculum for maintenance sessions.	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9884	Two Medicare Diabetes Prevention Program (MDPP) ongoing maintenance sessions (MS) were attended by an MDPP beneficiary in months (mo) 19-21 under the MDPP Expanded Model (EM). An ongoing maintenance session is an MDPP service that: (1) is furnished by an MDPP supplier during months 13 through 24 of the MDPP services period; (2) is approximately 1 hour in length; and (3) adheres to a CDC-approved DPP curriculum for maintenance sessions. The beneficiary maintained at least 5% weight loss (WL) from his/her baseline weight as measured by at least one in-person weight measurement at an ongoing maintenance session in months 19-21.	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9885	Two Medicare Diabetes Prevention Program (MDPP) ongoing maintenance sessions (MS) were attended by an MDPP beneficiary in months (mo) 22-24 under the MDPP Expanded Model (EM). An ongoing maintenance session is an MDPP service that: (1) is furnished by an MDPP supplier during months 13 through 24 of the MDPP services period; (2) is approximately 1 hour in length; and (3) adheres to a CDC-approved DPP curriculum for maintenance sessions.	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G9890	Bridge Payment: A one-time payment for the first Medicare Diabetes Prevention Program (MDPP) core session core maintenance session or ongoing maintenance session furnished by an MDPP supplier to an MDPP beneficiary during months 1-24 of the MDPP Expanded Model (EM) who has previously received MDPP services from a different MDPP supplier under the MDPP Expanded Model. A supplier may only receive one bridge payment per MDPP beneficiary.	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9891	MDPP session reported as a line-item on a claim for a payable MDPP Expanded Model (EM) HCPCS code for a session furnished by the billing supplier under the MDPP Expanded Model and counting toward achievement of the attendance performance goal for the payable MDPP Expanded Model HCPCS code.(This code is for reporting purposes only).	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9892	Documentation of patient reason(s) for not performing a dilated macular examination	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9893	Dilated macular exam was not performed reason not otherwise specified	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9894	Androgen deprivation therapy prescribed/administered in combination with external beam radiotherapy to the prostate	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9895	Documentation of medical reason(s) for not prescribing/administering androgen deprivation therapy in combination with external beam radiotherapy to the prostate (e.g. salvage therapy)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9896	Documentation of patient reason(s) for not prescribing/administering androgen deprivation therapy in combination with external beam radiotherapy to the prostate	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G9897	Patients who were not prescribed/administered androgen deprivation therapy in combination with external beam radiotherapy to the prostate reason not given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9898	Patients age 66 or older in institutional special needs plans (snp) or residing in long-term care with pos code 32 33 34 54 or 56 for more than 90 consecutive days during the measurement period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9899	Screening diagnostic film digital or digital breast tomosynthesis (3d) mammography results documented and reviewed	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9900	Screening diagnostic film digital or digital breast tomosynthesis (3d) mammography results were not documented and reviewed reason not otherwise specified	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9901	Patient age 66 or older in institutional special needs plans (snp) or residing in long-term care with pos code 32 33 34 54 or 56 for more than 90 consecutive days during the measurement period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9902	Patient screened for tobacco use and identified as a tobacco user	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9903	Patient screened for tobacco use and identified as a tobacco non-user	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9905	Patient not screened for tobacco use	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9906	Patient identified as a tobacco user received tobacco cessation intervention during the measurement period or in the six months prior to the measurement period (counseling and/or pharmacotherapy)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9908	Patient identified as tobacco user did not receive tobacco cessation intervention during the measurement period or in the six months prior to the measurement period (counseling and/or pharmacotherapy)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G9910	Patients age 66 or older in institutional special needs plans (snp) or residing in long-term care with pos code 32 33 34 54 or 56 for more than 90 consecutive days during the measurement period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9911	Clinically node negative (t1n0m0 or t2n0m0) invasive breast cancer before or after neoadjuvant systemic therapy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9912	Hepatitis b virus (hbv) status assessed and results interpreted prior to initiating anti-tnf (tumor necrosis factor) therapy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9913	Hepatitis b virus (hbv) status not assessed and results interpreted prior to initiating anti-tnf (tumor necrosis factor) therapy reason not otherwise specified	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9914	Patient receiving an anti-tnf agent	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9915	No record of hbv results documented	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9916	Functional status performed once in the last 12 months	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9917	Documentation of advanced stage dementia and caregiver knowledge is limited	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9918	Functional status not performed reason not otherwise specified	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9919	Screening performed and positive and provision of recommendations	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9920	Screening performed and negative	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9921	No screening performed partial screening performed or positive screen without recommendations and reason is not given or otherwise specified	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9922	Safety concerns screen provided and if positive then documented mitigation recommendations	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9923	Safety concerns screen provided and negative	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9925	Safety concerns screening not provided reason not otherwise specified	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9926	Safety concerns screening positive screen is without provision of mitigation recommendations including but not limited to referral to other resources	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G9927	Documentation of system reason(s) for not prescribing an fda-approved anticoagulation due to patient being currently enrolled in a clinical trial related to af/atrial flutter treatment	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9928	Fda-approved anticoagulant not prescribed reason not given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9929	Patient with transient or reversible cause of af (e.g. pneumonia hyperthyroidism pregnancy cardiac surgery)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9930	Patients who are receiving comfort care only	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9931	Documentation of cha2ds2-vasc risk score of 0 or 1 for men; or 0 1 or 2 for women	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9938	Patients age 66 or older in institutional special needs plans (snp) or residing in long-term care with pos code 32 33 34 54 or 56 for more than 90 consecutive days during the six months prior to the measurement period through december 31 of the measurement period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9939	Pathologists/dermatopathologists is the same clinician who performed the biopsy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9940	Documentation of medical reason(s) for not on a statin (e.g. pregnancy in vitro fertilization clomiphene rx esrd cirrhosis muscular pain and disease during the measurement period or prior year)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9943	Back pain was not measured by the visual analog scale (vas) or numeric pain scale at three months (6 - 20 weeks) postoperatively	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9945	Patient had cancer acute fracture or infection related to the lumbar spine or patient had neuromuscular idiopathic or congenital lumbar scoliosis	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9946	Back pain was not measured by the visual analog scale (vas) or numeric pain scale at one year (9 to 15 months) postoperatively	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9949	Leg pain was not measured by the visual analog scale (vas) or numeric pain scale at three months (6 - 20 weeks) postoperatively	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G9954	Patient exhibits 2 or more risk factors for post-operative vomiting	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9955	Cases in which an inhalational anesthetic is used only for induction	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9957	Documentation of medical reason for not receiving combination therapy consisting of at least two prophylactic pharmacologic anti-emetic agents of different classes preoperatively and/or intraoperatively (e.g. intolerance or other medical reason)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9958	Patient did not receive combination therapy consisting of at least two prophylactic pharmacologic anti-emetic agents of different classes preoperatively and/or intraoperatively	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9959	Systemic antimicrobials not prescribed	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9960	Documentation of medical reason(s) for prescribing systemic antimicrobials	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9961	Systemic antimicrobials prescribed	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9962	Embolization endpoints are documented separately for each embolized vessel and ovarian artery angiography or embolization performed in the presence of variant uterine artery anatomy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9963	Embolization endpoints are not documented separately for each embolized vessel or ovarian artery angiography or embolization not performed in the presence of variant uterine artery anatomy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9964	Patient received at least one well-child visit with a pcp during the performance period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9965	Patient did not receive at least one well-child visit with a pcp during the performance period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9968	Patient was referred to another clinician or specialist during the measurement period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G9969	Clinician who referred the patient to another clinician received a report from the clinician to whom the patient was referred	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9970	Clinician who referred the patient to another clinician did not receive a report from the clinician to whom the patient was referred	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9974	Dilated macular exam performed including documentation of the presence or absence of macular thickening or geographic atrophy or hemorrhage and the level of macular degeneration severity	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9975	Documentation of medical reason(s) for not performing a dilated macular examination	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9976	Documentation of patient reason(s) for not performing a dilated macular examination	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9977	Dilated macular exam was not performed reason not otherwise specified	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
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.	–	–	–
G9988	Palliative care services provided to patient any time during the measurement period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9990	Patient did not receive any pneumococcal conjugate or polysaccharide vaccine on or after their 60th birthday and before the end of the measurement period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G9991	Patient received any pneumococcal conjugate or polysaccharide vaccine on or after their 60th birthday and before the end of the measurement period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9992	Palliative care services used by patient any time during the measurement period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9993	Patient was provided palliative care services any time during the measurement period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9994	Patient is using palliative care services any time during the measurement period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9995	Patients who use palliative care services any time during the measurement period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9996	Documentation stating the patient has received or is currently receiving palliative or hospice care	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9997	Documentation of patient pregnancy anytime during the measurement period prior to and including the current encounter	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9998	Documentation of medical reason(s) for an interval of less than 3 years since the last colonoscopy (e.g. last colonoscopy incomplete last colonoscopy had inadequate prep piecemeal removal of adenomas last colonoscopy found greater than 10 adenomas or patient at high risk for colon cancer [crohn's disease ulcerative colitis lower gastrointestinal bleeding personal or family history of colon cancer hereditary colorectal cancer syndromes])	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9999	Documentation of system reason(s) for an interval of less than 3 years since the last colonoscopy (e.g. unable to locate previous colonoscopy report previous colonoscopy report was incomplete)	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.	–	–	–
H2015	Comprehensive Community Support Services Per 15 Minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

H2021	Community-Based Wrap-Around Services Per 15 Minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
H2038	Skills training and development per diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
J0129	Abatacept injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
J0172	Inj aducanumab-avwa 2 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
J0178	Injection Aflibercept 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
J0179	Injection brolucizumab-dbll 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	2/14/2023	Retired effective 02/14/2023
J0180	Injection Agalsidase Beta 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	10/14/2023	Retired effective 10/14/2023
J0202	Injection alemtuzumab	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) to avoid post-service review.	7/1/2023	_	Add effective 07/01/2023
J0219	Inj aval alfa-nqpt 4mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) to avoid post-service review.	_	_	_
J0220	Alglucosidase alfa injection	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
J0221	INJECTION ALGLUCOSIDASE ALFA (LUMIZYME) 10 MG	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	10/14/2023	Retired effective 10/14/2023
J0222	Inj. patisiran 0.1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) 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 (Predetermination) 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 (Predetermination) to avoid post-service review.	1/1/2023	_	Add effective 01/01/2023
J0256	Alpha 1 proteinase inhibitor	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
J0270	Alprostadil for injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_

J0275	Alprostadil urethral suppos	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
J0470	Injection Dimercaprol Per 100 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
J0490	INJECTION BELIMUMAB 10 MG	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) 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 (Predetermination) 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 (Predetermination) 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 (Predetermination) 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 (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
J0585	Injection onabotulinumtoxinA	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) 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 (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	1/31/2024	Retire effective 01/31/2024
J0588	INJECTION INCOBOTULINUMTOXIN A 1 UNIT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	1/31/2024	Retire effective 01/31/2024
J0591	Injection deoxycholic acid 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
J0593	Injection lanadelumab-flyo 1 mg (code may be used for Medicare when drug administered under direct supervision of a physician not for use when drug is self-administered)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
J0598	C-1 esterase cinryze	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	10/31/2023	Retire effective 10/31/2023

J0599	Injection c-1 esterase inhibitor (human) (haegarda) 10 units	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
J0600	Edetate calcium disodium inj	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
J0638	Canakinumab injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	10/31/2023	Retire effective 10/31/2023
J0717	Certolizumab pegol inj 1mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
J0739	Injection cabotegravir 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
J0741	Inj cabote rilpivir 2mg 3mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	2/15/2023	_	Add effective 02/15/2023
J0775	Collagenase clost hist inj	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) 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 (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
J0885	INJECTION EPOETIN ALFA (FOR NON-ESRD USE) 1000 UNITS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
J0888	Epoetin beta non esrd	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
J0895	Injection Deferoxamine Mesylate 500 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
J0897	INJECTION DENOSUMAB 1 MG	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	2/29/2024	Retire effective 02/29/2024
J1071	Injection Testosterone Cypionate 1Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
J1096	Dexamethasone lacrimal ophthalmic insert 0.1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
J1290	Ecallantide injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	10/31/2023	Retire effective 10/31/2023
J1300	Eculizumab injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	10/31/2023	Retire effective 10/31/2023

J1301	Injection edaravone 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
J1302	Inj sutimlimab-jome 10 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
J1303	Inj. ravulizumab-cwvz 10 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) 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 (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
J1322	Elosulfase alfa injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	10/14/2023	Retired Effective 10/14/2023
J1325	Epoprostenol injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) to avoid post-service review.	_	_	_
J1427	Inj. viltolarsen	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
J1428	Inj eteplirsen 10 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
J1429	Inj golodirsen 10 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
J1442	Injection filgrastim (g-csf) excludes biosimilars 1 microgram	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
J1447	Injection tbo-filgrastim 1 microgram	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
J1458	Injection Galsulfase 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	10/14/2023	Retired Effective 10/14/2023
J1551	Inj cutaquig 100 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_

J1566	Immune globulin powder	Unlisted Procedure; May require Prior Authorization per contract agreement.	_	_	_
J1599	Ivig non-lyophilized NOS	Unlisted Procedure; May require Prior Authorization per contract agreement.	_	_	_
J1602	Golimumab for iv use 1mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	10/31/2023	Retire effective 10/31/2023
J1620	Injection Gonadorelin Hydrochloride Per 100 Mcg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
J1627	Injection granisetron extended-release 0.1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
J1628	Injection guselkumab 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
J1632	Inj. brexanolone 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
J1675	Histrelin acetate	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
J1726	Makena 10 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	7/14/2023	Retire 07/14/2023
J1729	Inj hydroxyprogst capoat nos	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
J1743	Idursulfase injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	10/14/2023	Retired Effective 10/14/2023
J1745	Infliximab not biosimil 10mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	9/30/2023	Retire effective 09/30/2023
J1746	Inj. ibalizumab-uiyk 10 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
J1786	Injection Imiglucerase 10 Units	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	10/14/2023	Retired effective 10/14/2023
J1823	Inj. inebilizumab-cdon 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
J1930	INJECTION LANREOTIDE 1 MG	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
J1931	Injection Laronidase 0.1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	10/14/2023	Retired Effective 10/14/2023

J1932	Inj lanreotide (cipla) 1mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
J1950	Injection leuprolide acetate (for depot suspension) per 3. 75 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) to avoid post-service review.	_	_	_
J1952	Leuprolide injectable camcevi 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
J1954	Inj lutrate depot 7.5 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
J2182	Injection mepolizumab 1mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
J2320	Injection Nandrolone Decanoate Up To 50 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
J2327	Inj risankizumab-rzaa 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2023	_	Add effective 01/01/2023
J2350	Injection ocrelizumab 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	10/31/2023	Retire effective 10/31/2023
J2356	Inj tezepelumab-ekko 1mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
J2357	Omalizumab injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	10/31/2023	Retire effective 10/31/2023
J2440	Injection Papaverine Hcl Up To 60 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
J2502	Inj pasireotide long acting	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
J2503	Pegaptanib sodium injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	8/14/2023	Retire effective 08/14/2023
J2506	Injection pegfilgrastim excludes biosimilar 0.5 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
J2507	INJECTION PEGLOTICASE 1 MG	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_

J2562	INJECTION PLERIXAFOR 1 MG	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
J2777	Inj faricimab-svoa 0.1mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) to avoid post-service review.	_	_	_
J2779	Inj susvimo 0.1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
J2786	Injection reslizumab 1mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	10/14/2023	Retired effective 10/14/2023
J2787	Riboflavin 5'Phos opth<=3ml	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
J2820	Injection sargramostim (gm-csf) 50 mcg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
J2840	Inj sebelipase alfa 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	10/14/2023	Retired effective 10/14/2023
J3032	Inj. eptinezumab-jjmr 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
J3060	Injection Taliglucerace Alfa 10 Units	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	10/14/2023	Retired effective 10/14/2023
J3111	Injection romosozumab-aqqg 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
J3121	Inj testostero enanthate 1mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
J3241	Inj. teprotumumab-trbw 10 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
J3262	Tocilizumab injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	10/31/2023	Retire effective 10/31/2023

J3285	Treprostinil injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) to avoid post-service review.	_	_	_
J3316	Inj. triptorelin xr 3.75 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	9/30/2023	Retire effective 09/30/2023
J3355	Injection Urofollitropin 75 Iu	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
J3358	Ustekinumab iv inject 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	10/31/2023	Retire effective 10/31/2023
J3372	Inj vancomycin hcl (xellia)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	1/1/2023	Retired effective 01/31/2023
J3380	Injection vedolizumab	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
J3385	Injection Velaglucerase Alfa 100 Units	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	10/14/2023	Retired effective 10/14/2023
J3397	Inj. vestronidase alfa-vjbk	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	10/14/2023	Retired effective 10/14/2023
J3398	Inj luxturna 1 billion vec g	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
J3490	Drugs unclassified injection	Unlisted Procedure; May require Prior Authorization per contract agreement.	_	_	_
J3520	Edetate disodium per 150 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
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; May require Prior Authorization per contract agreement.	_	_	_
J3591	Esrd on dialysi drug/bio noc	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
J7177	Inj. fibryga 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) 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.	_	_	_
J7308	Aminolevulinic Acid Hcl For Topical Administration 20% Single Unit Dosage Form (354 Mg)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) to avoid post-service review.	_	_	_
J7311	Inj. retisert 0.01 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
J7312	Injection Dexamethasone Intravitreal Implant 0.1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
J7313	Inj. iluvien 0.01 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
J7314	Injection fluocinolone acetonide intravitreal implant (Yutiq) 0.01 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
J7316	Injection Ocriplasmin 0.125 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
J7318	Hyaluronan or derivative durolane for intra-articular injection 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
J7320	Hyaluronan or derivitive genvisc 850 for intra-articular injection 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
J7321	Hyaluronan or derivative hyalgan supartz or visco-3 for intra-articular injection per dose	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
J7322	Hyaluronan or derivative hymovis for intra-articular injection 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
J7323	HYALURONAN OR DERIVATIVE EUFLEXXA FOR INTRA-ARTICULAR INJECTION PER DOSE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
J7324	HYALURONAN OR DERIVATIVE ORTHOVISC FOR INTRA-ARTICULAR INJECTION PER DOSE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
J7325	HYALURONAN OR DERIVATIVE SYNVISC OR SYNVISC-ONE FOR INTRA-ARTICULAR INJECTION 1 MG	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
J7326	HYALURONAN OR DERIVATIVE GEL-ONE FOR INTRA-ARTICULAR INJECTION PER DOSE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
J7327	Hyaluronan or derivative monovisc for intra-articular injection per dose	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
J7328	Hyaluronan or derivative gel-syn for intra-articular injection 0.1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_

J7329	Hyaluronan or derivative trivisc for intra-articular injection 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
J7330	Autologous cultured chondrocytes implant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
J7331	Hyaluronan or derivative synojoynt for intra-articular injection 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
J7332	Hyaluronan or derivative triluron for intra-articular injection 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
J7340	Carbidopa levodopa ent 100ml	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	9/30/2023	Retire effective 09/30/2023
J7345	Aminolevulinic Acid Hcl For Topical Administration 10% Gel 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
J7351	Inj bimatoprost itc imp1mcg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
J7352	Afamelanotide implant 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	4/30/2023	Retire effective 04/30/2023
J7402	Mometasone sinus sinuva	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
J7508	Tacrolimus extended release (astagraf xl) oral 0.1 mg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
J7599	Immunosuppressive drug noc	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
J7604	Acetylcysteine comp unit	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
J7607	Levalbuterol comp con	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
J7609	Albuterol comp unit	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
J7610	Albuterol comp con	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
J7615	Levalbuterol comp unit	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
J7622	Beclomethasone comp unit	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
J7624	Betamethasone comp unit	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
J7627	Budesonide comp unit	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
J7628	Bitolterol mesylate comp con	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
J7629	Bitolterol mesylate comp unt	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
J7632	Cromolyn sodium comp unit	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
J7634	Budesonide comp con	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
J7635	Atropine comp con	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
J7636	Atropine comp unit	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_

J7637	Dexamethasone comp con	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
J7638	Dexamethasone comp unit	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
J7640	Formoterol comp unit	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
J7641	Flunisolide comp unit	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
J7642	Glycopyrrolate comp con	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
J7643	Glycopyrrolate comp unit	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
J7645	Ipratropium bromide comp	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
J7647	Isoetharine comp con	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
J7650	Isoetharine comp unit	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
J7657	Isoproterenol comp con	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
J7660	Isoproterenol comp unit	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
J7667	Metaproterenol comp con	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
J7670	Metaproterenol comp unit	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
J7676	Pentamidine comp unit dose	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
J7680	Terbutaline sulf comp con	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
J7681	Terbutaline sulf comp unit	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
J7683	Triamcinolone comp con	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
J7684	Triamcinolone comp unit	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
J7685	Tobramycin comp unit	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
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	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	–	–	–
J7999	Compounded drug noc	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
J8498	Antiemetic rectal/supp NOS	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
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.	–	–	–
J9021	Injection asparaginase recombinant (rylaze) 0.1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	–	–	–

J9032	Injection belinostat 10 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
J9035	INJECTION BEVACIZUMAB 10 MG	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	6/30/2023	Retire effective 06/30/2023
J9036	Injection bendamustine hydrochloride (Belrapzo/bendamustine) 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
J9061	Injection amivantamab-vmjw 2 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
J9153	Injection liposomal 1 mg daunorubicin and 2.27 mg cytarabine	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
J9155	INJECTION DEGARELIX 1 MG	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
J9202	Goserelin acetate implant per 3. 6 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
J9206	INJECTION IRINOTECAN 20 MG	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
J9210	Injection emapalumab-lzsg 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	4/30/2023	Retire effective 04/30/2023
J9215	INJECTION INTERFERON ALFA-N3 (HUMAN LEUKOCYTE DERIVED) 250 000 IU	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
J9217	Leuprolide acetate (for depot suspension) 7. 5 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
J9218	Leuprolide acetate per 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
J9219	Leuprolide acetate implant 65 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
J9225	Histrelin implant (vantas) 50 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
J9226	HISTRELIN IMPLANT (SUPPRELIN LA) 50 MG	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
J9247	Inj melphalan flufenami 1mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
J9262	Injection omacetaxine mepesuccinate 0.01 mg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_

J9272	Injection dostarlimab-gxly 10 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
J9273	Injection tisotumab vedotin-tftv 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
J9274	Inj tebentafusp-tebn 1 mcg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
J9285	Inj olaratumab 10 mg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
J9295	Injection necitumumab 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
J9311	Injection rituximab 10 mg and hyaluronidase	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
J9312	Injection rituximab 10 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
J9325	Injection talimogene laherparepvec per 1 million plaque forming units	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
J9331	Inj Sirolimus Prot Part 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
J9332	Inj efgartigimod 2mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
J9359	Injection loncastuximab tesirine-lpyl 0.075 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
J9400	Injection ziv-aflibercept 1 mg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
J9600	Porfimer sodium injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
J9999	Chemotherapy drug	Unlisted Procedure; May require Prior Authorization per contract agreement.	_	_	_
K0002	Stnd hemi (low seat) whlchr	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
K0003	Lightweight wheelchair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
K0004	High strength ltwt whlchr	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
K0005	Ultralightweight wheelchair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_

K0006	Heavy duty wheelchair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
K0007	Extra heavy duty wheelchair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
K0008	Cstm manual wheelchair/base	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
K0009	Other manual wheelchair/base	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) 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 (Predetermination) to avoid post-service review.	_	_	_
K0012	Ltwt portbl power whlchr	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
K0013	Custom power whlchr base	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
K0014	Other power whlchr base	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
K0046	Elevating legrest lower extension tube replacement only each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
K0047	Elevating legrest upper hanger bracket replacement only each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
K0051	Cam release assembly footrest or legrest replacement only each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
K0053	Elevate footrest articulate	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
K0056	Seat ht <17 or >=21 ltwt wc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
K0065	Spoke protectors	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
K0070	Rear wheel assembly complete with pneumatic tire spokes or molded each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
K0071	Front caster assembly complete with pneumatic tire replacement only each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
K0072	Front caster assembly complete with semi-pneumatic tire replacement only each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) to avoid post-service review.	_	_	_
K0108	W/c component-accessory NOS	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
K0195	Elevating leg rests pair (for use with capped rental wheelchair base)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_

K0455	Pump uninterrupted infusion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
K0462	Temporary replacement for patient owned equipment being repaired any type	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
K0669	Seat/back cus no dmepdac ver	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
K0743	SUCTION PUMP HOME MODEL PORTABLE FOR USE ON WOUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
K0744	ABSORPTIVE WOUND DRESSING FOR USE WITH SUCTION PUMP HOME MODEL PORTABLE PAD SIZE 16 SQUARE INCHES OR LESS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
K0745	Absorptive Wound Dressing For Use With Suction Pump, Home Model, Portable, Pad Size More Than 16 Square Inches But Less Than Or Equal To 48 Square Inches	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
K0746	ABSORPTIVE WOUND DRESSING FOR USE WITH SUCTION PUMP HOME MODEL PORTABLE PAD SIZE GREATER THAN 48 SQUARE INCHES	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) 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 (Predetermination) 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 (Predetermination) 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 (Predetermination) 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 (Predetermination) 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 (Predetermination) to avoid post-service review.	_	_	_
K0812	Power operated vehicle NOC	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
K0812	Power operated vehicle NOC	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
K0813	PWC gp 1 std port seat/back	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) 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 (Predetermination) 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 (Predetermination) 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 (Predetermination) 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 (Predetermination) 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 (Predetermination) 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 (Predetermination) 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 (Predetermination) to avoid post-service review.	_	_	_
K0825	PWC gp 2 hd cap chair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) 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 (Predetermination) 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 (Predetermination) 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 (Predetermination) 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 (Predetermination) 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 (Predetermination) 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 (Predetermination) 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 (Predetermination) 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 (Predetermination) 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 (Predetermination) to avoid post-service review.	_	_	_
K0839	PWC gp2 vhd sing pow opt s/b	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) 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 (Predetermination) 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 (Predetermination) 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 (Predetermination) 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 (Predetermination) 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 (Predetermination) 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 (Predetermination) 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 (Predetermination) 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 (Predetermination) 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 (Predetermination) to avoid post-service review.	_	_	_
K0854	PWC gp 3 xhd seat/back	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) 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 (Predetermination) 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 (Predetermination) 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 (Predetermination) 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 (Predetermination) 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 (Predetermination) 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 (Predetermination) 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 (Predetermination) 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 (Predetermination) 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 (Predetermination) to avoid post-service review.	_	_	_
K0868	PWC gp 4 std seat/back	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) 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 (Predetermination) 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 (Predetermination) 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 (Predetermination) to avoid post-service review.	_	_	_
K0878	PWC gp4 std sing pow opt cap	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
K0879	PWC gp4 hd sing pow opt s/b	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
K0880	PWC gp4 vhd sing pow opt s/b	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
K0884	PWC gp4 std mult pow opt s/b	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
K0885	PWC gp4 std mult pow opt cap	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) to avoid post-service review.	_	_	_
K0890	PWC gp5 ped sing pow opt s/b	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) to avoid post-service review.	_	_	_
K0898	Power wheelchair NOC	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
K0898	Power wheelchair NOC	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
K0899	Pow mobil dev no dmepdac	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
K0900	Customized Durable Medical Equipment Other Than Wheelchair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
K1001	Electronic positional obstructive sleep apnea treatment with sensor includes all components and accessories any type	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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).	_	_	_
K1013	Enema tube, any, replac only	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
K1014	Addition endoskeletal knee-shin system 4 bar linkage or multiaxial fluid swing and stance phase control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
K1016	Transcutaneous electrical nerve stimulator for electrical stimulation of the trigeminal nerve	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
K1017	Monthly supplies for use of device coded at k1016	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
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).	_	_	_
K1020	Non-invasive vagus nerv stim	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
K1021	Exsuff belt incl all sup acc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
K1022	Endoskel posit rotat unit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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).	_	_	_
K1024	Non pneum comp control cal	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	6/30/2023	Retire effective 06/30/2023
K1024	Non pneum comp control cal	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	7/1/2023	_	Add effective 07/01/2023
K1025	Non pneum compress full arm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	6/30/2023	Retire effective 06/30/2023
K1025	Non pneum compress full arm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	7/1/2023	_	Add effective 07/01/2023
K1027	Oral dev without fix mech	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
K1028	Control Unit Neuromuscul Osa	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
K1029	Oral Dv/App Neuromus Mouthpi	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
K1030	Ext recharge bat replacement	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_

K1031	Non pneu comp control w/o ca	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	6/30/2023	Retire effective 06/30/2023
K1031	Non pneu comp control w/o ca	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	7/1/2023	_	Add effective 07/01/2023
K1032	Non pneum seq comp full leg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	6/30/2023	Retire effective 06/30/2023
K1032	Non pneum seq comp full leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	7/1/2023	_	Add effective 07/01/2023
K1033	Non pneum seq comp half leg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	6/30/2023	Retire effective 06/30/2023
K1033	Non pneum seq comp half leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	7/1/2023	_	Add effective 07/01/2023
K1035	Mol Diag Reader Self-Admn	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/1/2023	_	Add effective 04/01/2023
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.	_	_	_
L1834	Ko w/0 joint rigid molded to	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L1840	Ko derot ant cruciate custom	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L1844	Ko w/adj jt rot cntrl molded	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L1846	Ko w adj flex/ext rotat mold	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L1860	Ko supracondylar socket mold	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L1960	Ankle foot orthosis posterior solid ankle plastic custom-fabricated	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	5/15/2023	Retire effective 05/15/2023
L1970	Ankle foot orthosis plastic with ankle joint custom-fabricated	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	5/15/2023	Retire effective 05/15/2023
L2006	Kaf Sng/Dbl Swg/Stn Mcpr Cus	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L2999	Lower extremity orthosis NOS	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
L3000	Foot insert removable molded to patient model 'ucb' type berkeley shell each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
L3001	Foot insert remov molded spe	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
L3002	Foot insert plastazote or eq	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
L3003	Foot insert silicone gel eac	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
L3010	Foot longitudinal arch suppo	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_

L3020	Foot longitud/metatarsal sup	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
L3030	Foot arch support remov prem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
L3031	Foot lamin/prepreg composite	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service 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.	–	–	–
L3070	Arch suprt att to sho longit	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
L3080	Arch supp att to shoe metata	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
L3090	Arch supp att to shoe long/m	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
L3100	Hallus-valgus nt dyn pre ots	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
L3140	Abduction rotation bar shoe	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
L3150	Abduct rotation bar w/o shoe	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
L3160	Shoe styled positioning dev	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
L3170	Foot plas heel stabi pre ots	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
L3201	Oxford w supinat/pronat inf	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
L3202	Oxford w/ supinat/pronator c	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
L3203	Oxford w/ supinator/pronator	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
L3204	Hightop w/ supp/pronator inf	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
L3206	Hightop w/ supp/pronator chi	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
L3207	Hightop w/ supp/pronator jun	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
L3212	Benesch boot pair infant	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
L3213	Benesch boot pair child	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
L3214	Benesch boot pair junior	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
L3215	Orthopedic ftwear ladies oxf	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
L3216	Orthoped ladies shoes dpth i	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
L3217	Ladies shoes hightop depth i	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
L3219	Orthopedic mens shoes oxford	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
L3221	Orthopedic mens shoes dpth i	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
L3222	Mens shoes hightop depth inl	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
L3230	Custom shoes depth inlay	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
L3250	Custom mold shoe remov prost	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

L3251	Shoe molded to pt silicone s	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
L3252	Shoe molded plastazote cust	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
L3253	Shoe molded plastazote cust	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
L3254	Orth foot non-stndard size/w	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
L3255	Orth foot non-standard size/	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
L3257	Orth foot add charge split s	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
L3265	Plastazote sandal each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
L3300	Sho lift taper to metatarsal	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
L3310	Shoe lift elev heel/sole neo	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
L3320	Shoe lift elev heel/sole cor	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
L3330	Lifts elevation metal extens	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
L3332	Shoe lifts tapered to one-ha	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
L3334	Shoe lifts elevation heel /i	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
L3340	Shoe wedge sach	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
L3350	Shoe heel wedge	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
L3360	Shoe sole wedge outside sole	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
L3370	Shoe sole wedge between sole	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
L3380	Shoe clubfoot wedge	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
L3390	Shoe outflare wedge	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
L3400	Shoe metatarsal bar wedge ro	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
L3410	Shoe metatarsal bar between	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
L3420	Full sole/heel wedge btween	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
L3430	Sho heel count plast reinfor	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
L3440	Heel leather reinforced	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
L3450	Shoe heel sach cushion type	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
L3455	Shoe heel new leather standa	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
L3460	Shoe heel new rubber standar	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
L3465	Shoe heel thomas with wedge	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
L3470	Shoe heel thomas extend to b	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
L3480	Shoe heel pad & depress for	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
L3485	Shoe heel pad removable for	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

L3500	Ortho shoe add leather insol	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
L3510	Orthopedic shoe add rub insl	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
L3520	O shoe add felt w leath insl	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
L3530	Ortho shoe add half sole	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
L3540	Ortho shoe add full sole	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
L3550	O shoe add standard toe tap	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
L3560	O shoe add horseshoe toe tap	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
L3570	O shoe add instep extension	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
L3580	O shoe add instep velcro clo	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
L3590	O shoe convert to sof counte	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
L3595	Ortho shoe add march bar	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
L3600	Trans shoe calip plate exist	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
L3610	Trans shoe caliper plate new	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
L3620	Trans shoe solid stirrup exi	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
L3630	Trans shoe solid stirrup new	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
L3640	Shoe dennis browne splint bo	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
L3649	Orthopedic shoe modifica NOS	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
L3999	Upper limb orthosis NOS	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
L5610	Above knee hydracadence	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L5611	Ak 4 bar link w/fric swing	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L5613	Ak 4 bar ling w/hydraul swig	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L5614	4-bar link above knee w/swng	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L5616	Ak univ multiplex sys frict	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L5620	Test socket below knee	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L5624	Test socket above knee	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L5629	Below knee acrylic socket	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_

L5631	Ak/knee disartic acrylic soc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L5638	Below knee leather socket	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L5639	Below knee wood socket	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L5640	Knee disarticulat leather so	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L5642	Above knee leather socket	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L5644	Above knee wood socket	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L5645	Bk flex inner socket ext fra	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L5646	Below knee cushion socket	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L5647	Below knee suction socket	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L5648	Above knee cushion socket	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L5651	Ak flex inner socket ext fra	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L5652	Suction susp ak/knee disart	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L5670	Bk molded supracondylar susp	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L5671	Addition to lower extremity below knee / above knee suspension locking mechanism (shuttle lanyard or equal) excludes socket insert	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L5672	Addition to lower extremity below knee removable medial brim suspension	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L5673	Addition to lower extremity below knee/above knee custom fabricated from existing mold or prefabricated socket insert silicone gel elastomeric or equal for use with locking mechanism	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L5704	Custom shape cover BK	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L5705	Custom shape cover AK	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_

L5706	Custom shape cvr knee disart	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L5714	Knee-shin exo variable frict	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L5722	Knee-shin pneum swg frct exo	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L5724	Knee-shin exo fluid swing ph	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L5726	Knee-shin ext jnts fld swg e	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L5728	Knee-shin fluid swg & stance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L5780	Knee-shin pneum/hydra pneum	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L5785	Exoskeletal bk ultralt mater	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L5790	Exoskeletal ak ultra-light m	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L5795	Exoskel hip ultra-light mate	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L5814	Endo knee-shin hydral swg ph	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L5816	Endo knee-shin polyc mch sta	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L5818	Endo knee-shin frct swg & st	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L5822	Endo knee-shin pneum swg frc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L5824	Endo knee-shin fluid swing p	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L5826	Miniature knee joint	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L5828	Endo knee-shin fluid swg/sta	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L5830	Endo knee-shin pneum/swg pha	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L5840	Multi-axial knee/shin system	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L5848	Knee-shin sys hydraul stance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_

L5856	Elec knee-shin swing/stance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) to avoid post-service review.	_	_	_
L5858	Stance phase only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L5859	Knee-shin pro flex/ext cont	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L5961	Endo poly hip pneu/hyd/rot	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L5962	Below knee flex cover system	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L5964	Above knee flex cover system	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L5966	Hip flexible cover system	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L5968	Multiaxial ankle w dorsiflex	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L5969	Ak/ft power asst incl motors	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L5970	Foot external keel sach foot	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) to avoid post-service review.	_	_	_
L5976	Energy storing foot	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L5978	Ft prosth multiaxial ankl/ft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L5979	Multi-axial ankle/ft prosth	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L5980	Flex foot system	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L5981	Flex-walk sys low ext prosth	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L5982	Exoskeletal axial rotation u	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L5984	Endoskeletal axial rotation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L5985	Lwr ext dynamic prosth pylon	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_

L5986	Multi-axial rotation unit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L5987	Shank ft w vert load pylon	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L5999	Lowr extremity prosthes NOS	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
L6026	Part hand myo exclu term dev	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L6611	Additional switch ext power	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L6621	Flex/ext wrist w/wo friction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L6646	Upper extremity addition shoulder joint multipositional locking flexion adjustable abduction friction control for use with body powered or external powered system	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L6648	Upper extremity addition shoulder lock mechanism external powered actuator	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L6715	Terminal Device Multiple Articulating Digit Includes Motor(S) Initial Issue Or Replacement	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L6880	ELECTRIC HAND SWITCH OR MYOLELECTRIC 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 (Predetermination) to avoid post-service review.	_	_	_
L6881	AUTOMATIC GRASP FEATURE ADDITION TO UPPER LIMB ELECTRIC PROSTHETIC TERMINAL DEVICE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L6882	Microprocessor control uplmb	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L6883	REPLACEMENT SOCKET BELOW ELBOW/WRIST DISARTICULATION MOLDED TO PATIENT MODEL FOR USE WITH OR WITHOUT EXTERNAL POWER	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L6884	REPLACEMENT SOCKET ABOVE ELBOW/ELBOW DISARTICULATION MOLDED TO PATIENT MODEL FOR USE WITH OR WITHOUT EXTERNAL POWER	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_

L6885	REPLACEMENT SOCKET SHOULDER DISARTICULATION/INTERSCAPULAR THORACIC MOLDED TO PATIENT MODEL FOR USE WITH OR WITHOUT EXTERNAL POWER	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L6920	Wrist disarticul switch ctrl	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L6925	Wrist disart myoelectronic c	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L6930	Below elbow switch control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L6935	Below elbow myoelectronic ct	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L6940	Elbow disarticulation switch	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L6945	Elbow disart myoelectronic c	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L6950	Above elbow switch control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L6955	Above elbow myoelectronic ct	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L6960	Shldr disartic switch contro	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L6965	Shldr disartic myoelectronic	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L6970	Interscapular-thor switch ct	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L6975	Interscap-thor myoelectronic	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L7007	Adult electric hand	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L7008	Pediatric electric hand	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L7009	Adult electric hook	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L7040	Prehensile actuator	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L7045	Pediatric electric hook	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L7170	Electronic elbow hosmer swit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_

L7180	Electronic elbow sequential	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L7181	Electronic elbo simultaneous	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L7185	Electron elbow adolescent sw	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L7186	Electron elbow child switch	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L7190	Elbow adolescent myoelectron	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L7191	Elbow child myoelectronic ct	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L7259	Electronic wrist rotator any	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L7360	Six volt bat otto bock/eq ea	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L7362	Battery chrgr six volt otto	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) 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 (Predetermination) to avoid post-service review.	_	_	_
L7367	Replacemnt lithium ionbatter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L7368	Lithium ion battery charger	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L7499	Upper extremity prosthes NOS	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
L7900	Male vacuum erection system	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L7902	Tension Ring Vac Erect Dev	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service 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.	_	_	_
L8600	Implant breast silicone/eq	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L8603	Collagen imp urinary 2.5 ml	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L8604	Dextranomer/hyaluronic acid	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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).	_	_	_
L8606	Synthetic implnt urinary 1ml	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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).	_	_	_
L8609	Artificial cornea	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L8612	Aqueous shunt prosthesis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L8613	Ossicula implant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L8614	Cochlear Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L8615	Coch Implant Headset Replace	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L8616	Coch Implant Microphone Repl	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L8617	Coch Implant Trans Coil Repl	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L8618	Coch Implant Tran Cable Repl	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L8619	Coch Imp Ext Proc/Contr Rplc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L8621	Repl Zinc Air Battery	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L8622	Repl Alkaline Battery	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L8623	Lith Ion Batt Cid Non-Earlvl	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L8624	Lith Ion Batt Cid Ear Level	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L8625	External recharging system for battery for use with cochlear implant or auditory osseointegrated device replacement only each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L8627	Cid Ext Speech Process Repl	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L8628	Cid Ext Controller Repl	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L8629	Cid Transmit Coil And Cable	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_

L8684	Radiofrequency transmitter (external) for use with implantable sacral root neurostimulator receiver for bowel and bladder management replacement	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L8690	Aud Osseo Dev Int/Ext Comp	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L8691	Aoi Snd Proc Repl Excl Actua	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L8692	AUDITORY OSSEOINTEGRATED DEVICE EXTERNAL SOUND PROCESSOR USED WITHOUT OSSEOINTEGRATION BODY WORN INCLUDES HEADBAND OR OTHER MEANS OF EXTERNAL ATTACHMENT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L8693	Aud Osseo Dev Abutment	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L8694	Aoi transducer/actuator repl	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L8698	Misc used with tot art heart	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L8699	Prosthetic implant NOS	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
L8701	Ewh s/d uprt micro sensor	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L8702	Ewhf s/d uprt micro sensor	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
M0001	Advancing cancer care mvp	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
M0002	Opt care kidney hlth mvp	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
M0003	Opt care episod neuro mvp	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
M0004	Support care neur cond mvp	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
M0005	Promot wellness mvp	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
M0010	Eom Meos Payment	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/1/2023	_	Add effective 04/01/2023
M0075	Cellular therapy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-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	_	Add effective 06/01/2023
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	_	Add effective 06/01/2023

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	–	Add effective 06/01/2023
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	–	Add effective 06/01/2023
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	–	Add effective 06/01/2023
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	–	Add effective 06/01/2023
M0300	IV chelationtherapy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	–	–	–
M0301	Fabric wrapping of aneurysm	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1003	Tb screening performed and results interpreted within twelve months prior to initiation of first-time biologic and/or immune response modifier therapy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1004	Documentation of medical reason for not screening for tb or interpreting results (i.e. patient positive for tb and documentation of past treatment; patient who has recently completed a course of anti-tb therapy)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1005	Tb screening not performed or results not interpreted reason not given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1006	Disease activity not assessed reason not given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1007	>=50% of total number of a patient's outpatient ra encounters assessed	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1008	<50% of total number of a patient's outpatient ra encounters assessed	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1009	Discharge/discontinuation of the episode of care documented in the medical record	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1010	Discharge/discontinuation of the episode of care documented in the medical record	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1011	Discharge/discontinuation of the episode of care documented in the medical record	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1012	Discharge/discontinuation of the episode of care documented in the medical record	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1013	Discharge/discontinuation of the episode of care documented in the medical record	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

M1014	Discharge/discontinuation of the episode of care documented in the medical record	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	
M1016	Female patients unable to bear children	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	
M1018	Patients with an active diagnosis or history of cancer (except basal cell and squamous cell skin carcinoma) patients who are heavy tobacco smokers lung cancer screening patients	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	
M1019	Adolescent patients 12 to 17 years of age with major depression or dysthymia who reached remission at twelve months as demonstrated by a twelve month (+/-60 days) phq-9 or phq-9m score of less than 5	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	
M1020	Adolescent patients 12 to 17 years of age with major depression or dysthymia who did not reach remission at twelve months as demonstrated by a twelve month (+/-60 days) phq-9 or phq-9m score of less than 5. either phq-9 or phq-9m score was not assessed or is greater than or equal to 5	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	
M1021	Patient had only urgent care visits during the performance period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	
M1027	Imaging of the head (ct or mri) was obtained	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	
M1028	Documentation of patients with primary headache diagnosis and imaging other than ct or mri obtained	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	
M1029	Imaging of the head (ct or mri) was not obtained reason not given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	
M1032	Adults currently taking pharmacotherapy for oud	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	
M1034	Adults who have at least 180 days of continuous pharmacotherapy with a medication prescribed for oud without a gap of more than seven days	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	
M1035	Adults who are deliberately phased out of medication assisted treatment (mat) prior to 180 days of continuous treatment	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	

M1036	Adults who have not had at least 180 days of continuous pharmacotherapy with a medication prescribed for oud without a gap of more than seven days	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1037	Patients with a diagnosis of lumbar spine region cancer at the time of the procedure	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1038	Patients with a diagnosis of lumbar spine region fracture at the time of the procedure	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1039	Patients with a diagnosis of lumbar spine region infection at the time of the procedure	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1040	Patients with a diagnosis of lumbar idiopathic or congenital scoliosis	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1041	Patient had cancer acute fracture or infection related to the lumbar spine or patient had neuromuscular idiopathic or congenital lumbar scoliosis	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1043	Functional status was not measured by the oswestry disability index (odi version 2.1a) at one year (9 to 15 months) postoperatively	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1045	Functional status measured by the oxford knee score (oks) at one year (9 to 15 months) postoperatively was greater than or equal to 37 or knee injury and osteoarthritis outcome score joint replacement (koos jr.) was greater than or equal to 71	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1046	Functional status measured by the oxford knee score (oks) at one year (9 to 15 months) postoperatively was less than 37 or the knee injury and osteoarthritis outcome score joint replacement (koos jr.) was less than 71 postoperatively	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1049	Functional status was not measured by the oswestry disability index (odi version 2.1a) at three months (6 - 20 weeks) postoperatively	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1051	Patient had cancer acute fracture or infection related to the lumbar spine or patient had neuromuscular idiopathic or congenital lumbar scoliosis	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

M1052	Leg pain was not measured by the visual analog scale (vas) or numeric pain scale at one year (9 to 15 months) postoperatively	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1054	Patient had only urgent care visits during the performance period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1055	Aspirin or another antiplatelet therapy used	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1056	Prescribed anticoagulant medication during the performance period history of gi bleeding history of intracranial bleeding bleeding disorder and specific provider documented reasons: allergy to aspirin or anti-platelets use of non-steroidal anti-inflammatory agents drug-drug interaction uncontrolled hypertension > 180/110 mmhg or gastroesophageal reflux disease	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1057	Aspirin or another antiplatelet therapy not used reason not given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1058	Patient was a permanent nursing home resident at any time during the performance period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1059	Patient was in hospice or receiving palliative care at any time during the performance period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1060	Patient died prior to the end of the performance period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1067	Hospice services for patient provided any time during the measurement period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1068	Adults who are not ambulatory	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1069	Patient screened for future fall risk	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1070	Patient not screened for future fall risk reason not given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1106	The start of an episode of care documented in the medical record	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1107	Documentation stating patient has a diagnosis of a degenerative neurological condition such as als ms or parkinson's diagnosed at any time before or during the episode of care	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

M1108	Ongoing care not clinically indicated because the patient needed a home program only referral to another provider or facility or consultation only as documented in the medical record	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1109	Ongoing care not medically possible because the patient was discharged early due to specific medical events documented in the medical record such as the patient became hospitalized or scheduled for surgery	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1110	Ongoing care not possible because the patient self-discharged early (e.g. financial or insurance reasons transportation problems or reason unknown)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1111	The start of an episode of care documented in the medical record	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1112	Documentation stating patient has a diagnosis of a degenerative neurological condition such as als ms or parkinson's diagnosed at any time before or during the episode of care	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1113	Ongoing care not clinically indicated because the patient needed a home program only referral to another provider or facility or consultation only as documented in the medical record	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1114	Ongoing care not medically possible because the patient was discharged early due to specific medical events documented in the medical record such as the patient became hospitalized or scheduled for surgery	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1115	Ongoing care not possible because the patient self-discharged early (e.g. financial or insurance reasons transportation problems or reason unknown)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1116	The start of an episode of care documented in the medical record	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

M1117	Documentation stating patient has a diagnosis of a degenerative neurological condition such as als ms or parkinson's diagnosed at any time before or during the episode of care	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1118	Ongoing care not clinically indicated because the patient needed a home program only referral to another provider or facility or consultation only as documented in the medical record	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1119	Ongoing care not medically possible because the patient was discharged early due to specific medical events documented in the medical record such as the patient became hospitalized or scheduled for surgery	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1120	Ongoing care not possible because the patient self-discharged early (e.g. financial or insurance reasons transportation problems or reason unknown)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1121	The start of an episode of care documented in the medical record	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1122	Documentation stating patient has a diagnosis of a degenerative neurological condition such as als ms or parkinson's diagnosed at any time before or during the episode of care	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1123	Ongoing care not clinically indicated because the patient needed a home program only referral to another provider or facility or consultation only as documented in the medical record	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1124	Ongoing care not medically possible because the patient was discharged early due to specific medical events documented in the medical record such as the patient became hospitalized or scheduled for surgery	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

M1125	Ongoing care not possible because the patient self-discharged early (e.g. financial or insurance reasons transportation problems or reason unknown)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1126	The start of an episode of care documented in the medical record	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1127	Documentation stating patient has a diagnosis of a degenerative neurological condition such as als ms or parkinson's diagnosed at any time before or during the episode of care	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1128	Ongoing care not clinically indicated because the patient needed a home program only referral to another provider or facility or consultation only as documented in the medical record	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1129	Ongoing care not medically possible because the patient was discharged early due to specific medical events documented in the medical record such as the patient became hospitalized or scheduled for surgery	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1130	Ongoing care not possible because the patient self-discharged early (e.g. financial or insurance reasons transportation problems or reason unknown)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1131	Documentation stating patient has a diagnosis of a degenerative neurological condition such as als ms or parkinson's diagnosed at any time before or during the episode of care	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1132	Ongoing care not clinically indicated because the patient needed a home program only referral to another provider or facility or consultation only as documented in the medical record	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

M1133	Ongoing care not medically possible because the patient was discharged early due to specific medical events documented in the medical record such as the patient became hospitalized or scheduled for surgery	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1134	Ongoing care not possible because the patient self-discharged early (e.g. financial or insurance reasons transportation problems or reason unknown)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1135	The start of an episode of care documented in the medical record	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1141	Functional status was not measured by the oxford knee score (oks) or the knee injury and osteoarthritis outcome score joint replacement (koos jr.) at one year (9 to 15 months) postoperatively	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1142	Emergent cases	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1143	Initiated episode of rehabilitation therapy medical or chiropractic care for neck impairment	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1146	Ongoing care not clinically indicated because the patient needed a home program only referral to another provider or facility or consultation only as documented in the medical record	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1147	Ongoing care not medically possible because the patient was discharged early due to specific medical events documented in the medical record such as the patient became hospitalized or scheduled for surgery	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1148	Ongoing care not possible because the patient self-discharged early (e.g. financial or insurance reasons transportation problems or reason unknown)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1149	Patient unable to complete the neck fs prom at initial evaluation and/or discharge due to blindness illiteracy severe mental incapacity or language incompatibility and an adequate proxy is not available	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

M1150	Lvef <=40% or mod/sev l vsf	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1151	Pt w/ hx trnsplt or lvad	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1152	Pt w/ hx trnsplt or lvad	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1153	Pt w/ dx osteo doe	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1154	Hospc serv dur meas pd	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1155	Pt anphx due to pneum	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1156	Pt recd actv chemo any time	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1157	Pt recd bone mar trnsplt	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1158	Pt hx immcomp prior/dur pd	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1159	Hospc serv dur meas pd	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1160	Pt anphx due to mengb bef 13	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1161	Pt anphx due to dtp bef 13	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1162	Pt enceph due to dtp bef 13	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1163	Pt anphx due to hpv bef 13	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1164	Pt w/ dementia any time	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1165	Pt use hspc dur meas pd	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1166	Path rpt tis spec wle/reexc	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1167	Hspc dur meas pd	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1168	Pt recd flu vax 7/1-6/30	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1169	Doc med rsn no flu vax	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1170	Pt w/o flu vax 7/1-6/30	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1171	Pt recd 1 td/tdap 9yrs prior	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1172	Doc med rsn no td/tdap	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1173	Pt no rec td/tdap 9yrs prior	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1174	Pt w/ 1 hzv lv or 2 hzv recm	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1175	Doc med rsn no hzv	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1176	Pt w/o hzv on/aft age 50	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1177	Pt recd pcv on/aft 60	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1178	Doc med rsn no pcv	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1179	No pcv recd	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1180	Pt imm ckpt inhib therapy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

M1181	Gr 2 or> dia or gr2 or> col	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1182	Not elg pre ex ibd/uc/crohn	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1183	Doc imm ckpt inhib hld	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1184	Doc med rsn no cst/ist rx	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1185	Imm ckpt inhib not hld no rx	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1186	Pt w/ rx for hspc/plltv care	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1187	Pt w/ esrd	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1188	Pt w/ ckd stg 5	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1189	Doc khe pef w/efgr/uacr	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1190	Doc khe not pef w/efgr/uacr	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1191	Hspc svc any time in meas pd	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1192	Pt w/ dx sq cell ca of esoph	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1193	Rpts w/ imp/con mmr/msi	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1194	Med rsn no imp/con mmr/msi	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1195	Rpt wo imp/con mmr/msi	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1196	Ixv nrs vrs iqa >=4	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1197	Isa red >=2 fr ixv	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1198	Isa not red 2pts fr ixv	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1199	Pt rec'g rrt	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1200	Ace-i/arb rx	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1201	Med rsn no ace-i/arb rx	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1202	Pt rsn no ace-i/arb rx	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1203	No rsn ace-i/arb rx	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1204	Ixv nrs vrs iqa >=4	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1205	Isa red >=2 fr ixv	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1206	Isa not red 2pts fr ixv	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1207	#pts scrn sdoh	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1208	#pts no scrn sdoh	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1209	>=2 same hi-rsk med w/o diag	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M1210	>=2 same meds tbl4 not ord	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

P2031	Hair analysis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
P9603	One-way allow prorated miles	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
P9604	One-way allow prorated trip	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
P9615	Catheterization for collection of specimen (s) (multiple patients)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
Q0092	Set-up portable x-ray equipment	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service 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	_	Add effective 06/01/2023
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	_	Add effective 06/01/2023
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	_	Add effective 06/01/2023
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	_	Add effective 06/01/2023
Q0477	Pwr module pt cable lvad rpl	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
Q0478	Power adapter combo vad	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
Q0479	Power module combo vad rep	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
Q0480	Driver pneumatic vad rep	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
Q0481	Microprcsr cu elec vad rep	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
Q0482	Microprcsr cu combo vad rep	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
Q0483	Monitor elec vad rep	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
Q0484	Monitor elec or comb vad rep	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
Q0485	Monitor cable elec vad rep	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
Q0486	Mon cable elec/pneum vad rep	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
Q0487	Leads any type vad rep only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_

Q0488	Pwr pack base elec vad rep	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
Q0489	Pwr pck base combo vad rep	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
Q0490	Emr pwr source elec vad rep	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
Q0491	Emr pwr source combo vad rep	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
Q0492	Emr pwr cbl elec vad rep	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
Q0493	Emr pwr cbl combo vad rep	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
Q0494	Emr hd pmp elec/combo rep	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
Q0495	Charger elec/combo vad rep	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
Q0496	Battery elec/combo vad rep	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
Q0497	Bat clps elec/comb vad rep	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
Q0498	Holster elec/combo vad rep	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
Q0499	Belt/vest elec/combo vad rep	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
Q0500	Filters elec/combo vad rep	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
Q0501	Shwr cov elec/combo vad rep	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
Q0502	Mobility cart pneum vad rep	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
Q0503	Battery pneum vad replacemnt	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
Q0504	Pwr adpt pneum vad rep veh	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
Q0506	Lith-ion batt elec/pneum VAD	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
Q0507	Misc sup/acc ext VAD	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
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	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service 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	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service 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 immunosupressive	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.	_	_	_
Q0513	PHARMACY DISPENSING FEE FOR INHALATION DRUG(S); PER 30 DAYS	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
Q0514	PHARMACY DISPENSING FEE FOR INHALATION DRUG(S); PER 90 DAYS	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
Q0515	INJECTION SERMORELIN ACETATE 1 MICROGRAM	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
Q2026	Radiesse injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
Q2028	Inj sculptra 0.5mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 ciloleucel car+	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
Q2042	Tisagenlecleucel car-pos t	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
Q2050	Doxorubicin inj 10mg	Unlisted Procedure; May require Prior Authorization per contract agreement.	_	_	_
Q2052	Ivig demo services/supplies	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
Q2053	Brexucabtagene car pos t	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) 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 (Predetermination) 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 (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
Q3014	Telehealth originating site facility fee	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
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	Unlisted: Procedure/service 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 (Predetermination) to avoid post-service review.	_	_	_
Q4100	Skin substitute NOS	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
Q4101	Apligraf	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
Q4102	Oasis wound matrix	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
Q4103	Oasis burn matrix	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, 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).	_	_	_
Q4105	Integra drt or omnigraft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
Q4106	Dermagraft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
Q4107	Graftjacket	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
Q4108	Integra matrix	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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).	_	_	_
Q4114	Integra flowable wound matri	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
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).	_	_	_
Q4116	Alloderm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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).	_	_	_
Q4122	Dermacell awm porous sq cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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).	_	_	_
Q4128	Flexhd/allopatchhd/sq cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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).	_	_	_
Q4132	Grafix core grafixpl core	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
Q4133	Grafix stravix prime pl sqcm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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).	_	_	_
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).	_	_	_
Q4151	Amnioband guardian 1 sq cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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).	_	_	_
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).	_	_	_
Q4154	Biovance 1 square cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
Q4155	Neoxflo or clarixflo 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).	_	_	_
Q4159	Affinity1 square cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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).	_	_	_

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).	_	_	_
Q4168	Amnioband 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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).	_	_	_
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).	_	_	_
Q4186	Epifix 1 sq cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
Q4187	Epicord 1 sq cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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).	_	_	_
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).	_	_	_
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).	_	_	_
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).	_	_	_
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).	_	_	_
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).	_	_	_
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	Amniply 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).	_	_	_
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	_	Add effective 01/01/2023
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	_	Add effective 01/01/2023
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	_	Add effective 01/01/2023
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	_	Add effective 09/01/2023
Q4265	Neostim Tl Per Sq Cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	6/1/2023	8/31/2023	Add effective 06/01/2023; Retire effective 08/31/2023
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	_	Add effective 09/01/2023
Q4266	Neostim Per Sq Cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	6/1/2023	8/31/2023	Add effective 06/01/2023; Retire effective 08/31/2023
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	_	Add effective 09/01/2023

Q4267	Neostim Dl Per Sq Cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	6/1/2023	8/31/2023	Add effective 06/01/2023; Retire effective 08/31/2023
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	_	Add effective 09/01/2023
Q4268	Surgraft Ft Per Sq Cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	6/1/2023	8/31/2023	Add effective 06/01/2023; Retire effective 08/31/2023
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	_	Add effective 09/01/2023
Q4269	Surgraft Xt Per Sq Cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	6/1/2023	8/31/2023	Add effective 06/01/2023; Retire effective 08/31/2023
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	_	Add effective 09/01/2023
Q4270	Complete Sl Per Sq Cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	6/1/2023	8/31/2023	Add effective 06/01/2023; Retire effective 08/31/2023
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	_	Add effective 09/01/2023
Q4271	Complete Ft Per Sq Cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	6/1/2023	8/31/2023	Add effective 06/01/2023; Retire effective 08/31/2023
Q5009	Hospice care NOS	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
Q5010	HOSPICE HOME CARE PROVIDED IN A HOSPICE FACILITY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
Q5101	Injection filgrastim-sndz biosimilar (zarxio) 1 microgram	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
Q5103	Injection inflectra	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	9/30/2023	Retired effective 09/30/2023
Q5106	Inj retacrit non-esrd use	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
Q5108	Injection pegfilgrastim-jmdb biosimilar (fulphila) 0.5 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
Q5110	Injection filgrastim-aafi biosimilar (nivestym) 1 microgram	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
Q5120	Injection pegfilgrastim-bmez biosimilar (ziextenzo) 0.5 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
Q5121	Injection infliximab-axxq biosimilar (avsola) 10 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	6/30/2023	Retire effective 06/30/2023
Q5122	Injection pegfilgrastim-apgf biosimilar (nyvepria) 0.5 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
Q5124	Inj. byooviz 0.1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
Q5125	Inj, releuko 1 mcg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	3/31/2023	Retire effective 03/31/2023; check PA list
Q5128	_	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	6/1/2023	_	Add effective 06/01/2023
Q9001	Assessment by chaplain services	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
Q9002	Counseling individual by chaplain services	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
Q9003	Counseling group by chaplain services	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
Q9004	Va whole health partner serv	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
Q9969	Tc-99m from non-highly enriched uranium source full cost recovery add-on per study dose	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
R0070	Transportation of portable x-ray equipment and personnel to home or nursing home per trip to facility or location one patient seen	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
R0075	Transportation of portable x-ray equipment and personnel to home or nursing home per trip to facility or location more than one patient seen	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
R0076	Transportation of portable ekg to facility or location per patient	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S0013	Esketamine nasal spray	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
S0126	Inj follitropin alfa 75 iu	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_

S0128	Inj follitropin beta 75 iu	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S0132	Injection ganirelix acetate 250 mcg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
S0155	Epoprostenol dilutant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
S0157	Becaplermin gel 1% 0.5 gm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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.	_	_	_
S0207	Paramedicintercep nonhospals	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
S0208	Paramedic intercept hospital-based als service (non-voluntary) non-transport	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
S0209	WC van mileage per mi	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S0215	Nonemerg transp mileage	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
S0260	History and physical (outpatient or office) related to surgical procedure (list separately in addition to code for appropriate evaluation and management service)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S0271	PHYSICIAN MANAGEMENT OF PATIENT HOME CARE HOSPICE MONTHLY CASE RATE (PER 30 DAYS)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S0302	Completed early periodic screening diagnosis and treatment (epsdt) service (list in addition to code for appropriate evaluation and management service)	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.	_	_	_
S0340	Lifestyle modification program for management of coronary artery disease including all supportive services; first quarter / stage	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S0341	Lifestyle modification program for management of coronary artery disease including all supportive services; second or third quarter / stage	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S0342	Lifestyle modification program for management of coronary artery disease including all supportive services; fourth quarter / stage	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_

S0390	Rout foot care per visit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
S0395	Impression casting of a foot performed by a practitioner other than the manufacturer of the orthotic	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S0510	Non-prscrp lens	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S0516	Safety frames	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S0518	Sunglass frames	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.	_	_	_
S0596	Phakic iol refractive error	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
S0800	Laser in situ keratomileusis	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S0810	Photorefractive keratectomy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S0812	Phototherap keratect	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
S1001	Deluxe item	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
S1002	Custom item	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
S1030	Gluc monitor purchase	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
S1031	Gluc monitor rental	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
S1034	Art pancreas system	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
S1035	Art pancreas inv disp sensor	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
S1036	Art pancreas ext transmitter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
S1037	Art pancreas ext receiver	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
S1040	Cranial remolding orthosis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
S1091	Stent non-coronary propel	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
S2053	Transplantation of small intestine and liver allografts	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
S2054	Transplantation of multivisceral organs	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_

S2055	Harvesting of donor multivisceral organs with preparation and maintenance of allografts; from cadaver donor	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
S2060	Lobar lung transplantation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
S2061	Donor lobectomy (lung) for transplantation living donor	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
S2065	Simultaneous pancreas kidney transplantation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
S2080	Laup	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
S2083	Adjustment gastric band	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
S2095	Transcath emboliz microspher	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
S2102	Islet cell tissue transplant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
S2103	Adrenal tissue transplant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
S2107	Adoptive immunotherapy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
S2112	Knee arthroscp harv	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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).	_	_	_
S2118	Total hip resurfacing	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
S2120	Low Density Lipoprotein(Ldl)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
S2140	Cord blood harvesting	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
S2142	Cord blood-derived stem-cell	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
S2150	BMT harv/transpl 28d pkg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_

S2152	Solid organ(s) complete or segmental single organ or combination of organs; deceased or living donor (s) procurement transplantation and related complications; including: drugs; supplies; hospitalization with outpatient follow-up; medical/surgical diagnostic emergency and rehabilitative services and the number of days of pre- and post-transplant care in the global definition	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
S2202	Echosclerotherapy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
S2230	Implant semi-imp hear	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
S2235	Implant auditory brain imp	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
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).	_	_	_
S2348	Decompress disc RF lumbar	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
S2400	Fetal surg congen hernia	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
S2401	Fetal surg urin trac obstr	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
S2402	Fetal surg cong cyst malf	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
S2403	Fetal surg pulmon sequest	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
S2404	Fetal surg myelomeningo	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
S2405	Fetal surg sacrococ teratoma	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
S2409	Fetal surg noc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
S2409	Fetal surg noc	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
S2411	Fetoscop laser ther TTTS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-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).	_	_	_
S4011	IVF package	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S4013	Compl GIFT case rate	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S4014	Compl ZIFT case rate	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S4015	Complete IVF nos case rate	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
S4016	Frozen IVF case rate	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S4017	IVF canc a stim case rate	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S4018	F EMB trns canc case rate	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S4020	IVF canc a aspir case rate	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S4021	IVF canc p aspir case rate	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S4022	Asst oocyte fert case rate	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S4023	Incompl donor egg case rate	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S4025	Donor serv IVF case rate	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S4026	Procure donor sperm	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S4027	Store prev froz embryos	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S4028	Microsurg epi sperm asp	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S4030	Sperm procure init visit	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S4031	Sperm procure subs visit	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S4037	Cryo embryo transf case rate	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S4040	Monit store cryo embryo 30 d	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S4042	Ovulation mgmt per cycle	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-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.	_	_	_
S5108	Homecare train pt 15 min	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
S5110	Family homecare training 15m	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
S5111	Family homecare train/sessio	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_

S5130	Homaker service nos per 15m	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not specifically defined or classified, 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: Procedure/service not specifically defined or classified, maybe subject to contract/clinical 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.	–	–	–
S5181	HH respiratory thrpy nos/day	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
S5199	Personal care item nos each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
S5497	HIT cath care noc	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
S8035	Magnetic source imaging	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
S8040	Topographic brain mapping	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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).	_	_	_
S8185	Flutter device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
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	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
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).	_	_	_
S8948	Low-level laser trmt 15 min	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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.	–	–	–
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).	_	_	_
S9024	Paranasal sinus ultrasound	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
S9055	Procuren or other growth fac	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_

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).	_	_	_
S9117	Back school visit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
S9122	Home health aide or certifie	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
S9123	Nursing care in the home; by registered nurse per hour (use for general nursing care only not to be used when cpt codes 99500-99602 can be used)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
S9124	Nursing care in the home; by licensed practical nurse per hour	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
S9128	Speech therapy in the home	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
S9129	Occupational therapy in the	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
S9131	PT in the home per diem	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
S9145	Insulin pump initiation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
S9208	Home management of preterm labor including administrative services professional pharmacy services care coordination and all necessary supplies or equipment (drugs and nursing visits coded separately) per diem (do not use this code with any home infusion per diem code)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
S9335	HT hemodialysis diem	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
S9340	HIT enteral per diem	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
S9341	HIT enteral grav diem	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
S9342	HIT enteral pump diem	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
S9343	HIT enteral bolus nurs	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
S9355	HIT chelation diem	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_

S9364	HIT tpn total diem	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
S9365	Home infusion therapy total parenteral nutrition (tpn); one liter per day administrative services professional pharmacy services care coordination and all necessary supplies and equipment including standard tpn formula (lipids specialty amino acid formulas drugs other than in standard formula and nursing visits coded separately) per diem	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
S9366	HIT tpn 2 liter diem	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
S9367	HIT tpn 3 liter diem	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
S9368	HIT tpn over 3l diem	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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.	_	_	_
S9430	Pharmacy comp/disp serv	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
S9432	Med food non inborn err meta	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
S9433	MEDICAL FOOD NUTRITIONALLY COMPLETE ADMINISTERED ORALLY PROVIDING 100% OF NUTRITIONAL INTAKE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
S9445	PT education noc individ	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
S9446	PT education noc group	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
S9449	Weight mgmt class	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S9537	HT hem horm inj diem	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
S9542	HT inj noc per diem	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
S9542	HT inj noc per diem	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
S9558	HT inj growth horm diem	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
S9560	HT inj hormone diem	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_

S9562	HT inj palivizumab diem	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
S9810	HT pharm per hour	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
S9810	HT pharm per hour	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
S9960	Air ambulanc nonemerg fixed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
S9961	Air ambulan nonemerg rotary	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-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: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
S9977	Meals per diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
S9988	Serv part of phase I trial	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
S9990	Services provided as part of	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
S9991	Services provided as part of	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-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.	_	_	_
T1000	Private duty / independent nursing service(s) - licensed up to 15 minutes	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.	_	_	_
T1030	Nursing care in the home by registered nurse per diem	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
T1031	Nursing care in the home by licensed practical nurse per diem	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
T1032	Sv doula brth wrk per 15 min	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
T1033	Sv doula brth wrk per diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
T1040	Medicaid certified community behavioral health clinic services per diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_

T1041	Medicaid certified community behavioral health clinic services per month	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	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
T2013	Habil ed waiver per hour	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
T2014	Habil prevoc waiver per d	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
T2015	Habil prevoc waiver per hr	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
T2016	Habil res waiver per diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
T2017	Habil res waiver 15 min	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
T2018	Habil sup empl waiver/diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
T2019	Habil sup empl waiver 15min	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
T2020	Day habil waiver per diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
T2021	Day habil waiver per 15 min	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
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	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
T2027	Spec childcare waiver 15 min	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
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	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
T2031	Assist living waiver/diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
T2032	Res care nos waiver/month	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
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	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
T2036	Camp overnite waiver/session	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
T2037	Camp day waiver/session	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
T2038	Comm trans waiver/service	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
T2039	Vehicle mod waiver/service	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
T2040	Financial mgt waiver/15min	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
T2041	Support broker waiver/15 min	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
T2047	Habilitation prevocational waiver; per 15 minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
T2050	Financial Mgt Waiver/Diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
T2051	Support broker waiver/diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
T2101	Breast milk proc/store/dist	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
T4536	Reusable pull-on any size	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
T4537	Reusable underpad bed size	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
T4538	Diaper serv reusable diaper	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
T4539	Reuse diaper/brief any size	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
T4540	Reusable underpad chair size	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

T4541	Large disposable underpad	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
T4542	Small disposable underpad	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
T4543	Adult disp brief/diap abv xl	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
T4544	Adult sized disposable incontinence product protective underwear/pull-on above extra large each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
T4545	Incontinence product disposable penile wrap each	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.	–	–	–
V2523	Contact lens hydrophilic extended wear per lens	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	–	–	–
V2524	Contact lens hydrophilic spherical photochromic additive per lens	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	–	–	–
V2530	Contact lens scleral gas impermeable per lens (for contact lens modification see 92325)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	–	–	–
V2531	Contact lens scleral gas permeable per lens (for contact lens modification see 92325)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	–	–	–
V2599	Contact lens/es other type	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
V2600	Hand held low vision aids	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
V2627	Scleral cover shell	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service 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.	–	–	–
V2744	Tint photochromatic lens/es	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
V2745	Tint any color/solid/grad	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
V2750	Anti-reflective coating	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
V2755	UV lens/es	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
V2756	Eye glass case	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
V2760	Scratch resistant coating	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
V2761	Mirror coating	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
V2762	Polarization any lens	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

V2787	Astigmatism-correct function	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
V2788	Presbyopia-correct function	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
V2790	Amniotic membrane	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
V2799	Misc vision item or service	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
V2799	Misc vision item or service	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
V5011	Fitting/orientation/checking of hearing aid	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
V5090	Hearing aid dispensing fee	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
V5095	Implant mid ear hearing pros	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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.	_	_	_
V5268	Assistive listening device telephone amplifier any type	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
V5269	Alerting device any type	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
V5271	ALD TV caption decoder	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
V5272	Tdd	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
V5273	ALD for cochlear implant	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
V5274	ALD unspecified	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
V5281	Assistive listening device personal fm/dm system monaural (1 receiver transmitter microphone) any type	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
V5282	Assistive listening device personal fm/dm system binaural (2 receivers transmitter microphone) any type	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
V5283	Assistive listening device personal fm/dm neck loop induction receiver	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
V5284	Assistive listening device personal fm/dm ear level receiver	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
V5285	Assistive listening device personal fm/dm direct audio input receiver	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
V5286	Assistive listening device personal blue tooth fm/dm receiver	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
V5287	Ald fm/dm receiver NOS	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_

V5288	Assistive listening device personal fm/dm transmitter assistive listening device	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
V5289	Assistive listening device personal fm/dm adapter/boot coupling device for receiver any type	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
V5290	Assistive listening device transmitter microphone any type	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service 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.	–	–	–
V5336	Repair/modification of augmentative communicative system or device (excludes adaptive hearing aid)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
H0041	Fos c chld non-ther per diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	–	Add effective 01/01/2023
H0042	Fos c chld non-ther per mon	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	–	Add effective 01/01/2023
H0043	Supported housing per diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	–	Add effective 01/01/2023
H0044	Supported housing per month	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	–	Add effective 01/01/2023
H1010	Nonmed family planning ed	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	–	Add effective 01/01/2023
H2023	Supported employ per 15 min	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	–	Add effective 01/01/2023
H2024	Supported employ per diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	–	Add effective 01/01/2023
H2025	Supp maint employ 15 min	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	–	Add effective 01/01/2023
H2026	Supp maint employ per diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	–	Add effective 01/01/2023
H2030	MH clubhouse svc per 15 min	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	–	Add effective 01/01/2023
H2031	MH clubhouse svc per diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	–	Add effective 01/01/2023
S5100	Adult daycare services 15min	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	–	Add effective 01/01/2023
S5101	Adult day care per half day	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	–	Add effective 01/01/2023
S5102	Adult day care per diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	–	Add effective 01/01/2023
S5105	Centerbased day care perdiem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	–	Add effective 01/01/2023
S5120	Chore services per 15 min	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	–	Add effective 01/01/2023
S5121	Chore services per diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	–	Add effective 01/01/2023
S5135	Adult companioncare per 15m	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	–	Add effective 01/01/2023
S5136	Adult companioncare per diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	–	Add effective 01/01/2023
S5140	Adult foster care per diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	–	Add effective 01/01/2023
S5141	Adult foster care per month	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	–	Add effective 01/01/2023

S5145	Child fostercare th per diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	–	Add effective 01/01/2023
S5146	Ther fostercare child /month	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	–	Add effective 01/01/2023
S5170	Homedelivered prepared meal	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	–	Add effective 01/01/2023
S5175	Laundry serv ext prof /order	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/18/2023	–	Add effective 04/18/2023
91300	SARSCOV2 VAC 30MCG/0.3ML IM	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/18/2023	10/31/2023	Add effective 04/18/2023 Retire effective 10/31/2023
91301	SARSCOV2 VAC 100MCG/0.5ML IM	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/18/2023	10/31/2023	Add effective 04/18/2023 Retire effective 10/31/2023
91305	SARSCOV2 VAC 30 MCG TRS-SUCR	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/18/2023	10/31/2023	Add effective 04/18/2023 Retire effective 10/31/2023
91306	SARSCOV2 VAC 50MCG/0.25ML IM	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/18/2023	10/31/2023	Add effective 04/18/2023 Retire effective 10/31/2023
91307	SARSCOV2 VAC 10 MCG TRS-SUCR	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/18/2023	10/31/2023	Add effective 04/18/2023 Retire effective 10/31/2023
91308	SARSCOV2 VAC 3 MCG TRS-SUCR	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/18/2023	10/31/2023	Add effective 04/18/2023 Retire effective 10/31/2023
91309	SARSCOV2 VAC 50MCG/0.5ML IM	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/18/2023	10/31/2023	Add effective 04/18/2023 Retire effective 10/31/2023
91311	SARSCOV2 VAC 25MCG/0.25ML IM	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/18/2023	10/31/2023	Add effective 04/18/2023 Retire effective 10/31/2023
0001A	ADM SARSCOV2 30MCG/0.3ML 1ST	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/18/2023	10/31/2023	Add effective 04/18/2023 Retire effective 10/31/2023
0002A	ADM SARSCOV2 30MCG/0.3ML 2ND	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/18/2023	10/31/2023	Add effective 04/18/2023 Retire effective 10/31/2023

0003A	ADM SARSCOV2 30MCG/0.3ML 3RD	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/18/2023	10/31/2023	Add effective 04/18/2023 Retire effective 10/31/2023
0004A	ADM SARSCOV2 30MCG/0.3ML BST	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/18/2023	10/31/2023	Add effective 04/18/2023 Retire effective 10/31/2023
0011A	ADM SARSCOV2 100MCG/0.5ML1ST	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/18/2023	10/31/2023	Add effective 04/18/2023 Retire effective 10/31/2023
0012A	ADM SARSCOV2 100MCG/0.5ML2ND	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/18/2023	10/31/2023	Add effective 04/18/2023 Retire effective 10/31/2023
0013A	ADM SARSCOV2 100MCG/0.5ML3RD	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/18/2023	10/31/2023	Add effective 04/18/2023 Retire effective 10/31/2023
0051A	ADM SARSCV2 30MCG TRS-SUCR 1	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/18/2023	10/31/2023	Add effective 04/18/2023 Retire effective 10/31/2023
0052A	ADM SARSCV2 30MCG TRS-SUCR 2	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/18/2023	10/31/2023	Add effective 04/18/2023 Retire effective 10/31/2023
0053A	ADM SARSCV2 30MCG TRS-SUCR 3	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/18/2023	10/31/2023	Add effective 04/18/2023 Retire effective 10/31/2023
0054A	ADM SARSCV2 30MCG TRS-SUCR B	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/18/2023	10/31/2023	Add effective 04/18/2023 Retire effective 10/31/2023
0064A	ADM SARSCOV2 50MCG/0.25MLBST	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/18/2023	10/31/2023	Add effective 04/18/2023 Retire effective 10/31/2023
0071A	ADM SARSCV2 10MCG TRS-SUCR 1	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/18/2023	10/31/2023	Add effective 04/18/2023 Retire effective 10/31/2023
0072A	ADM SARSCV2 10MCG TRS-SUCR 2	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/18/2023	10/31/2023	Add effective 04/18/2023 Retire effective 10/31/2023

0073A	ADM SARSCV2 10MCG TRS-SUCR 3	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/18/2023	10/31/2023	Add effective 04/18/2023 Retire effective 10/31/2023
0074A	ADM SARSCV2 10MCG TRS-SUCR B	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/18/2023	10/31/2023	Add effective 04/18/2023 Retire effective 10/31/2023
0081A	ADM SARSCV2 3MCG TRS-SUCR 1	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/18/2023	10/31/2023	Add effective 04/18/2023 Retire effective 10/31/2023
0082A	ADM SARSCV2 3MCG TRS-SUCR 2	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/18/2023	10/31/2023	Add effective 04/18/2023 Retire effective 10/31/2023
0083A	ADM SARSCV2 3MCG TRS-SUCR 3	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/18/2023	10/31/2023	Add effective 04/18/2023 Retire effective 10/31/2023
0091A	ADM SARSCOV2 50 MCG/.5 ML1ST	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/18/2023	10/31/2023	Add effective 04/18/2023 Retire effective 10/31/2023
0092A	ADM SARSCOV2 50 MCG/.5 ML2ND	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/18/2023	10/31/2023	Add effective 04/18/2023 Retire effective 10/31/2023
0093A	ADM SARSCOV2 50 MCG/.5 ML3RD	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/18/2023	10/31/2023	Add effective 04/18/2023 Retire effective 10/31/2023
0094A	ADM SARSCOV2 50 MCG/.5 MLBST	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/18/2023	10/31/2023	Add effective 04/18/2023 Retire effective 10/31/2023
0111A	ADM SARSCOV2 25MCG/0.25ML1ST	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/18/2023	10/31/2023	Add effective 04/18/2023 Retire effective 10/31/2023
0112A	ADM SARSCOV2 25MCG/0.25ML2ND	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/18/2023	10/31/2023	Add effective 04/18/2023 Retire effective 10/31/2023
0113A	ADM SARSCOV2 25MCG/0.25ML3RD	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/18/2023	10/31/2023	Add effective 04/18/2023 Retire effective 10/31/2023

J1411	Inj hemgenix per tx dose	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	5/1/2023	–	Add effective 05/01/2023
J1747	Inj spesolimab-sbzo 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	5/1/2023	–	Add effective 05/01/2023
91303	SARSCOV2 VAC AD26 .5ML IM	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/7/2023	10/31/2023	Add effective 05/07/2023 retire effective 10/31/2023
0031A	ADM SARSCOV2 VAC AD26 .5ML	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/7/2023	10/31/2023	Add effective 05/07/2023 retire effective 10/31/2023
0034A	ADM SARSCOV2 VAC AD26 .5ML B	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/7/2023	10/31/2023	Add effective 05/07/2023 retire effective 10/31/2023
A2019	Kerecis marigen shld sq cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	5/15/2023	8/31/2023	Add effective 05/15/2023; Retire effective 08/31/2023
A7049	Epap nasal valve	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	5/15/2023	8/31/2023	Add effective 05/15/2023; Retire effective 08/31/2023
C7507	Perq thor&lumb vert aug	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	5/1/2023	–	Add effective 05/01/2023
C7508	Perq lumb&thor vert aug	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	5/1/2023	–	Add effective 05/01/2023
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	–	Add effective 09/01/2023
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	–	Add effective 09/01/2023
0388U	ONC NONSM CLL LNG CA 37 GEN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	7/1/2023	9/30/2023	Add effective 07/1/2023
0391U	ONC SLD TUM DNA&RNA 437 GEN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	7/1/2023	9/30/2023	Add effective 07/01/2023
0392U	RX METAB GENRX IA 16 GENES	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	7/1/2023	9/30/2023	Add effective 07/01/2023
0395U	ONC LNG MULTIOMICS PLSM ALG	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	7/1/2023	9/30/2023	Add effective 07/01/2023
0396U	OB PREIMPLTJ TST 300000 DNA	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	7/1/2023	9/30/2023	Add effective 07/01/2023

0397U	ONC NONSM CLL LNG CA 109	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	7/1/2023	9/30/2023	Add effective 07/01/2023 Retire 09/30/2023
0399U	NEURO CERE FOLATE DEFNCY SRM	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	7/1/2023	9/30/2023	Add effective 07/01/2023 Retire effective 09/30/2023
0400U	OB XPND CAR SCR 145 GENES	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	7/1/2023	9/30/2023	Add effective 07/01/2023
0401U	CRD C HRT DS 9 GEN 12 VRNTS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	7/1/2023	9/30/2023	Add effective 07/01/2023
0792T	APPL SLVR DIAMN FLUORIDE 38%	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	7/1/2023	12/31/2999	Add effective 07/01/2023
0794T	PT SPEC ALG RX-ONC TX OPTION	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	7/1/2023	12/31/2999	Add effective 07/01/2023
0809T	ARTHRD SI JT PRQ TFX&IMPLT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	7/1/2023	11/30/2023	Add effective 07/01/2023 Retire 11/30/2023
C9784	Endo sleeve gastro w/tube	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	7/1/2023	11/30/2023	Add effective 07/01/2023 Retire 11/30/2023
C9785	Endo outlet restrict w/tube	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	7/1/2023	11/30/2023	Add effective 07/01/2023 Retire 11/30/2023
C9787	Gastric ep mapg simult pt sx	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	7/1/2023	12/31/2999	Add effective 07/01/2023
J1440	Fecal microbiota jslm 1 ml	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	7/1/2023	12/31/2999	Add effective 07/01/2023
J1576	Inj panzyga 500 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	7/1/2023	12/31/2999	Add effective 07/01/2023
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	Add effective 07/15/2023
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	Add effective 07/15/2023
J1961	Inj lenacapavir 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	7/1/2023	12/31/2999	Add effective 07/01/2023
J2329	Inj ublituximab-xiiy 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	7/1/2023	12/31/2999	Add effective 07/01/2023
J9029	Inj adstiladrin per tx dos	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	7/1/2023	12/31/2999	Add effective 07/01/2023
J9056	Inj bendamustine 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	7/1/2023	12/31/2999	Add effective 07/01/2023

J9058	Inj apotex/bendamustine 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	7/1/2023	12/31/2999	Add effective 07/01/2023
J9059	Inj bendamustine baxter 1mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	7/1/2023	12/31/2999	Add effective 07/01/2023
J9259	Paclitaxel (american regent)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	7/1/2023	12/31/2999	Add effective 07/01/2023
J9350	Inj mosunetuzumab-axgb 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	7/1/2023	12/31/2999	Add effective 07/01/2023
J9380	Inj teclistamab cqyv 0.5 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	7/1/2023	12/31/2999	Add effective 07/01/2023
L8678	Ext sply implt neurostim	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	7/15/2023	12/31/2999	Add effective 07/15/2023
Q4272	Esano a per sq cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	7/1/2023	11/30/2023	Add effective 07/01/2023 Retire 11/30/2023
Q4273	Esano aaa per sq cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	7/1/2023	11/30/2023	Add effective 07/01/2023 Retire 11/30/2023
Q4274	Esano ac per sq cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	7/1/2023	11/30/2023	Add effective 07/01/2023 Retire 11/30/2023
Q4275	Esano aca per sq cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	7/1/2023	11/30/2023	Add effective 07/01/2023 Retire 11/30/2023
Q4276	Orion per sq cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	7/1/2023	11/30/2023	Add effective 07/01/2023 Retire 11/30/2023
Q4277	Woundplus e-grat per sq cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	7/1/2023	11/30/2023	Add effective 07/01/2023 Retire 11/30/2023
Q4278	Epieffect per sq cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	7/1/2023	11/30/2023	Add effective 07/01/2023 Retire 11/30/2023
Q4280	Xcell amnio matrix per sq cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	7/1/2023	11/30/2023	Add effective 07/01/2023 Retire 11/30/2023
Q4281	Barrera slor dl per sq cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	7/1/2023	11/30/2023	Add effective 07/01/2023 Retire 11/30/2023
Q4282	Cygnus dual per sq cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	7/1/2023	11/30/2023	Add effective 07/01/2023 Retire 11/30/2023
Q4283	Biovance tri or 3l sq cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	7/1/2023	12/31/2999	Add effective 07/01/2023

Q4284	Dermabind sl per sq cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	7/1/2023	11/30/2023	Add effective 07/01/2023 Retire 11/30/2023
J9381	Inj teplizumab mzwv 5 mcg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	8/1/2023	12/31/2999	Add effective 08/01/2023
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	Add effective 12/01/2023
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	Add effective 12/01/2023
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	Add effective 12/01/2023
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	Add effective 12/01/2023
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	Add effective 12/01/2023
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	Add effective 12/01/2023
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	Add effective 12/01/2023
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	Add effective 12/01/2023
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	Add effective 12/01/2023
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	Add effective 12/01/2023
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	Add effective 12/01/2023
J3396	Verteporfin injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	8/15/2023	12/31/2999	Add effective 08/15/2023
J0179	Inj brolucizumab-dbll 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	8/15/2023	12/31/2999	Add effective 08/15/2023
J0174	Inj lecanemab-irmb 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	7/6/2023	12/31/2999	Add effective 07/06/2023
C9786	Echo cad for hf preserved ef	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	8/1/2023	12/31/2999	Add effective 08/01/2023
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	Add effective 12/01/2023
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	Add effective 12/01/2023
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	Add effective 12/01/2023

0570T	TTVR PERQ EA ADDL PROSTH	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	8/15/2023	12/31/2999	Add effective 08/15/2023
0569T	TTVR PERQ APPR 1ST PROSTH	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	8/15/2023	12/31/2999	Add effective 08/15/2023
0545T	TCAT TV ANNULUS RCNSTJ	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	8/15/2023	12/31/2999	Add effective 08/15/2023
A4341	Iduc valve pat inst repl	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	11/15/2023	12/31/2999	Add effective 11/15/2023
A4342	Iduc valve sply repl	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	11/15/2023	12/31/2999	Add effective 11/15/2023
J7183	INJECTION VON WILLEBRAND FACTOR COMPLEX (HUMAN) WILATE 1 I.U. VWF:RCO	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	3/1/2024	12/31/2999	Add effective 03/01/2024
0740T	REM AUTON ALG NSLN CAL SETUP	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	9/1/2023	12/31/2999	Add effective 09/01/2023
0741T	REM AUTON ALG NSLN DATA COLL	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	9/1/2023	12/31/2999	Add effective 09/01/2023
98978	REM THER MNTR DEV SPLY CBT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	9/1/2023	12/31/2999	Add effective 09/01/2023
J2796	Romiplostim injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) 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 (Predetermination) 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 (Predetermination) 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 (Predetermination) to avoid post-service review.	3/1/2024	12/31/2999	Add effective 03/01/2024
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	Add effective 10/01/2023
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	Add effective 10/01/2023
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	Add effective 10/01/2023
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	Add effective 10/01/2023
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	Add effective 10/01/2023
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	Add effective 10/01/2023
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	Add effective 10/01/2023

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	Add effective 10/01/2023
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	Add effective 10/01/2023
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	Add effective 10/01/2023
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 01/15/2024
C9157	Injection, tofersen, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	10/1/2023	12/31/2999	Add effective 10/01/2023
A4560	Nmes disposable	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	10/15/2023	1/14/2024	Add effective 10/15/2023 Retire effective 01/14/2024
V2526	Cntct lens blue violet	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	10/1/2023	12/31/2999	Add effective 10/01/2023
J2781	Inj pegcetacoplan 1mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	10/1/2023	12/31/2999	Add effective 10/01/2023
G0330	Facility svs dental rehab	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2023	12/31/2999	Add effective 01/01/2023
C9792	Blind/nonblind trans atrial	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	10/1/2023	12/31/2999	Add effective 10/01/2023
C9156	Flotufolastat f18 dia 1 mci	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	10/1/2023	12/31/2999	Add effective 10/01/2023
A9573	Inj gadopiclenol 1 ml	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	10/1/2023	12/31/2999	Add effective 10/01/2023
0419U	NRPSYC GEN SEQ VRNT ALY 13	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	10/1/2023	12/31/2999	Add effective 10/01/2023
0417U	RARE DS ALYS 335 NUC GENES	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	10/1/2023	12/31/2999	Add effective 10/01/2023
0413U	ONC HL NEO OPT GEN MAPG DNA	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	10/1/2023	12/31/2999	Add effective 10/01/2023
0412U	BETA AMYLOID A?42/40 IMPRCIP	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	10/1/2023	12/31/2999	Add effective 10/01/2023
0411U	PSYC GENOM ALYS PNL 15 GEN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	10/1/2023	12/31/2999	Add effective 10/01/2023
0410U	ONC PNCRTC DNA WHL GN SEQ 5-	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	10/1/2023	12/31/2999	Add effective 10/01/2023
0405U	ONC PNCRTC 59 MTHLTN BLK MRK	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	10/1/2023	12/31/2999	Add effective 10/01/2023
0322U	NEURO ASD MEAS 14 ACYL CARN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	4/1/2022	1/31/2024	Retire Effective 01/31/2024

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 02/1/2024
41872	REPAIR GUM	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	2/1/2024	12/31/2999	Add effective 02/01/2024