



**2024 Recommended Clinical Review, Post-Service Review and Non-Covered Procedure Code
List - Fully Insured
Effective 1/1/2024
(Updated February 2024)**

<p>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:</p> <ul style="list-style-type: none">- Subject to a medical necessity review,- Candidates for a Recommended Clinical Review ,- 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) <p>Except as otherwise noted in the date column, these codes are effective on or before January 1, 2024.</p>			<p>Utilization Management Process</p> <p>This file is a searchable PDF.</p> <p>Press "CTRL" and "F" keys at the same time to bring up the search box. Enter a procedure code or description of the service.</p>		
Procedure Code Groups		Procedure Code Group Description			
Medical Policy Criteria (MP Criteria)		Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review 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)		Procedures/services not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).			
Unlisted or Undefined		Procedures/services not specifically defined or classified, may be subject to contract/clinical review.			
Note: Some codes will appear twice if Ending Date and Effective Date are within the same quarter period.					
Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date	Updates
00640	ANESTH SPINE MANIPULATION	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
00797	ANESTH SURGERY FOR OBESITY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–

11200	REMOVAL OF SKIN TAGS <W/15	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
11201	REMOVE SKIN TAGS ADD-ON	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
11950	TX CONTOUR DEFECTS 1 CC/<	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
11951	TX CONTOUR DEFECTS 1.1-5.0CC	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
11952	TX CONTOUR DEFECTS 5.1-10CC	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
11954	TX CONTOUR DEFECTS >10.0 CC	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
11960	INSERT TISSUE EXPANDER(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
11970	RPLCMT TISS XPNDR PERM IMPLT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
11980	IMPLANT HORMONE PELLET(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
11981	INSERTION DRUG DLVR IMPLANT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
11983	REMOVE/INSERT DRUG IMPLANT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
15271	Skin Sub Graft Trnk/Arm/Leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2023	—	—
15272	Skin Sub Graft T/A/L Add-On	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2023	—	—

15273	Skin Sub Grft T/Arm/Lg Child	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2023	—	—
15274	Skn Sub Grft T/A/L Child Add	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2023	—	—
15275	Skin Sub Graft Face/Nk/Hf/G	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2023	—	—
15276	Skin Sub Graft F/N/Hf/G Addl	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2023	—	—
15277	Skn Sub Grft F/N/Hf/G Child	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2023	—	—
15278	Skn Sub Grft F/N/Hf/G Ch Add	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2023	—	—
15758	FREE FASCIAL FLAP MICROVASC	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
15769	GRFG AUTOL SOFT TISS DIR EXC	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
15771	GRFG AUTOL FAT LIPO 50 CC/<	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
15772	GRFG AUTOL FAT LIPO EA ADDL	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
15775	HAIR TRNSPL 1-15 PUNCH GRFTS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
15776	HAIR TRNSPL >15 PUNCH GRAFTS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
15780	DERMABRASION TOTAL FACE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—

15781	DERMABRASION SEGMENTAL FACE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
15782	DERMABRASION OTHER THAN FACE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
15783	DERMABRASION SUPRFL ANY SITE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
15786	ABRASION LESION SINGLE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
15787	ABRASION LESIONS ADD-ON	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
15788	CHEMICAL PEEL FACE EPIDERM	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
15789	CHEMICAL PEEL FACE DERMAL	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
15792	CHEMICAL PEEL NONFACIAL	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
15793	CHEMICAL PEEL NONFACIAL	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
15819	PLASTIC SURGERY NECK	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
15820	REVISION OF LOWER EYELID	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
15821	REVISION OF LOWER EYELID	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
15822	REVISION OF UPPER EYELID	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
15823	REVISION OF UPPER EYELID	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–

15824	REMOVAL OF FOREHEAD WRINKLES	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, and may require Prior Authorization per contract agreement.	—	1/31/2024	Retire effective 01/31/2024
15825	REMOVAL OF NECK WRINKLES	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
15826	REMOVAL OF BROW WRINKLES	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, and may require Prior Authorization per contract agreement.	—	1/31/2024	Retire effective 01/31/2024
15828	REMOVAL OF FACE WRINKLES	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
15829	REMOVAL OF SKIN WRINKLES	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
15830	EXC SKIN ABD	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
15832	EXCISE EXCESSIVE SKIN THIGH	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
15833	EXCISE EXCESSIVE SKIN LEG	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
15834	EXCISE EXCESSIVE SKIN HIP	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
15835	EXCISE EXCESSIVE SKIN BUTTCK	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
15836	EXCISE EXCESSIVE SKIN ARM	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
15837	EXCISE EXCESS SKIN ARM/HAND	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
15838	EXCISE EXCESS SKIN FAT PAD	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—

15839	EXCISE EXCESS SKIN & TISSUE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
15847	EXC SKIN ABD ADD-ON	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
15876	SUCTION LIPECTOMY HEAD&NECK	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
15877	SUCTION LIPECTOMY TRUNK	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
15878	SUCTION LIPECTOMY UPR EXTREM	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
15879	SUCTION LIPECTOMY LWR EXTREM	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
15999	UNLISTED PX EXC PRESSURE ULC	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
17106	DESTRUCTION OF SKIN LESIONS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
17107	DESTRUCTION OF SKIN LESIONS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
17108	DESTRUCTION OF SKIN LESIONS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
17360	SKIN PEEL THERAPY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
17380	HAIR REMOVAL BY ELECTROLYSIS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
17999	UNLISTD PX SKN MUC MEMB SUBQ	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–

19105	CRYOSURG ABLATE FA EACH	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
19300	REMOVAL OF BREAST TISSUE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
19303	MAST SIMPLE COMPLETE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
19316	SUSPENSION OF BREAST	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, and may require Prior Authorization per contract agreement.	—	4/14/2024	Retire effective 04/14/2024
19318	BREAST REDUCTION	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, and may require Prior Authorization per contract agreement.	6/15/2023	1/31/2024	Add effective 06/15/2023 Retire effective 01/31/2024
19325	BREAST AUGMENTATION W/IMPLT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
19328	RMVL INTACT BREAST IMPLANT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
19330	RMVL RUPTURED BREAST IMPLANT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
19340	INSJ BREAST IMPLT SM D MAST	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
19342	INSJ/RPLCMT BRST IMPLT SEP D	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
19350	BREAST RECONSTRUCTION	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
19355	CORRECT INVERTED NIPPLE(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
19357	TISS XPNDR PLMT BRST RCNSTJ	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—

19370	REVJ PERI-IMPLT CAPSULE BRST	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
19371	PERI-IMPLT CAPSLC BRST COMPL	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
19499	UNLISTED PROCEDURE BREAST	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.; Procedures/services not specifically defined or classified, maybe subject to contract/clinical 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 to avoid post-service review.	–	–	–
20560	NDL INSJ W/O NJX 1 OR 2 MUSC	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
20561	NDL INSJ W/O NJX 3+ MUSC	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
20979	US BONE STIMULATION	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review 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 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 to avoid post-service review.	–	–	–
20985	CPTR-ASST DIR MS PX	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
20999	UNLISTED PX MUSCSKEL GENERAL	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
21032	REMOVE EXOSTOSIS MAXILLA	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

21073	MNPJ OF TMJ W/ANESTH	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
21083	PREPARE FACE/ORAL PROSTHESIS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
21089	UNLISTED MAXLFCL PROSTH PX	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
21120	RECONSTRUCTION OF CHIN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
21121	RECONSTRUCTION OF CHIN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
21122	RECONSTRUCTION OF CHIN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
21123	RECONSTRUCTION OF CHIN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
21244	RECONSTRUCTION OF LOWER JAW	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
21245	RECONSTRUCTION OF JAW	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
21246	RECONSTRUCTION OF JAW	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
21248	RECONSTRUCTION OF JAW	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
21249	RECONSTRUCTION OF JAW	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
21299	UNLISTED CRANFCL&MAXLFCL PX	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
21499	UNLISTED MUSCSKEL PX HEAD	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–

21899	UNLISTED PX NECK/THORAX	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
22505	MANIPULATION OF SPINE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
22526	IDET SINGLE LEVEL	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
22527	IDET 1 OR MORE LEVELS	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
22586	ARTHRD PRE-SAC NTRBDY L5-S1	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
22867	INSJ STABLJ DEV W/DCMPRN	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
22868	INSJ STABLJ DEV W/DCMPRN	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
22869	INSJ STABLJ DEV W/O DCMPRN	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
22870	INSJ STABLJ DEV W/O DCMPRN	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
22899	UNLISTED PROCEDURE SPINE	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
22999	UNLISTED PX ABDOMEN MUSCSKEL	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
23929	UNLISTED PROCEDURE SHOULDER	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.; Procedures/services not specifically defined or classified, maybe subject to contract/clinical 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 to avoid post-service review.	–	–	–
24999	UNLISTED PX HUMERUS/ELBOW	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
25259	MANIPULATE WRIST W/ANESTHES	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
25999	UNLISTED PX FOREARM/WRIST	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
26340	MANIPULATE FINGER W/ANESTH	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
26341	MANIPULAT PALM CORD POST INJ	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
26989	UNLISTED PX HANDS/FINGERS	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
27275	MANIPULATION OF HIP JOINT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
27299	UNLISTED PX PELVIS/HIP JOINT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.; Procedures/services not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
27299	UNLISTED PX PELVIS/HIP JOINT	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
27599	UNLISTED PX FEMUR/KNEE	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–

27702	RECONSTRUCT ANKLE JOINT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
27703	RECONSTRUCTION ANKLE JOINT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
27860	FIXATION OF ANKLE JOINT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
27899	UNLISTED PX LEG/ANKLE	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
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.	–	–	–
29862	HIP ARTHRO W/DEBRIDEMENT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review 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 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 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 to avoid post-service review.	–	–	–
29914	HIP ARTHRO W/FEMOROPLASTY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
29915	HIP ARTHRO ACETABULOPLASTY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
29916	HIP ARTHRO W/LABRAL REPAIR	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–

29999	UNLISTED PX ARTHROSCOPY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.; Procedures/services not specifically defined or classified, maybe subject to contract/clinical review.	—	—	—
29999	UNLISTED PX ARTHROSCOPY	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	—	—	—
30468	RPR NSL VLV COLLAPSE W/IMPLT	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	—	—	—
30469	RPR NSL VLV COLLAPSE W/RMDLG	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	1/1/2023	—	—
30999	UNLISTED PROCEDURE NOSE	Unlisted Procedure; May require Prior Authorization per contract agreement.	—	—	—
31299	UNLISTED PX ACCESSORY SINUS	Unlisted Procedure; May require Prior Authorization per contract agreement.	—	—	—
31599	UNLISTED PROCEDURE LARYNX	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	—	—	—
31647	BRONCHIAL VALVE INIT INSERT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
31648	BRONCHIAL VALVE REMOV INIT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
31649	BRONCHIAL VALVE REMOV ADDL	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
31651	BRONCHIAL VALVE ADDL INSERT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
31660	BRONCH THERMOPLSTY 1 LOBE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
31661	BRONCH THERMOPLSTY 2/> LOBES	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—

31899	UNLISTED PX TRACHEA BRONCHI	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
32994	ABLATE PULM TUMOR PERQ CRYBL	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
32998	ABLATE PULM TUMOR PERQ RF	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
32999	UNLISTED PX LUNGS & PLEURA	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
33211	INSERT CARD ELECTRODES DUAL	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review 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 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 to avoid post-service review.	–	–	–
33267	EXCL LAA OPEN ANY METHOD	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
33268	EXCL LAA OPN OTH PX ANY METH	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
33269	EXCL LAA THRSCP ANY METHOD	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
33274	TCAT INSJ/RPL PERM LDLS PM	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
33285	INSJ SUBQ CAR RHYTHM MNTR	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
33289	TCAT IMPL WRLS P-ART PRS SNR	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–

33361	REPLACE AORTIC VALVE PERQ	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
33362	REPLACE AORTIC VALVE OPEN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
33363	REPLACE AORTIC VALVE OPEN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
33364	REPLACE AORTIC VALVE OPEN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
33365	REPLACE AORTIC VALVE OPEN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
33366	TRCATH REPLACE AORTIC VALVE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review 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 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 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 to avoid post-service review.	—	—	—
33418	REPAIR TCAT MITRAL VALVE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
33419	REPAIR TCAT MITRAL VALVE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
33477	IMPLANT TCAT PULM VLV PERQ	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review 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 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 to avoid post-service review.	—	—	—
33999	UNLISTED PX CARDIAC SURGERY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.; Procedures/services not specifically defined or classified, maybe subject to contract/clinical 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 to avoid post-service review.	—	—	—
36466	NJX NONCMPND SCLRSNT MLT VN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
36468	NJX SCLRSNT SPIDER VEINS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
36470	NJX SCLRSNT 1 INCMPTNT VEIN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
36471	NJX SCLRSNT MLT INCMPTNT VN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
36475	ENDOVENOUS RF 1ST VEIN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
36476	ENDOVENOUS RF VEIN ADD-ON	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
36478	ENDOVENOUS LASER 1ST VEIN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—

36479	ENDOVENOUS LASER VEIN ADDON	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
36482	ENDOVEN THER CHEM ADHES 1ST	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
36483	ENDOVEN THER CHEM ADHES SBSQ	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
36522	PHOTOPHERESIS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
36836	PRQ AV FSTL CRTJ UXTR 1 ACS	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	1/1/2023	–	–
36837	PRQ AV FSTL CRT UXTR SEP ACS	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	1/1/2023	–	–
37215	TRANSCATH STENT CCA W/EPS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
37216	TRANSCATH STENT CCA W/O EPS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
37217	STENT PLACEMT RETRO CAROTID	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
37218	STENT PLACEMT ANTE CAROTID	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
37241	VASC EMBOLIZE/OCCLUDE VENOUS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
37242	VASC EMBOLIZE/OCCLUDE ARTERY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
37243	VASC EMBOLIZE/OCCLUDE ORGAN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–

37244	VASC EMBOLIZE/OCCLUDE BLEED	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
37500	ENDOSCOPY LIGATE PERF VEINS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
37501	UNLISTED VASC ENDOSCOPY PX	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
37700	REVISE LEG VEIN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
37718	LIGATE/STRIP SHORT LEG VEIN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
37722	LIGATE/STRIP LONG LEG VEIN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
37735	REMOVAL OF LEG VEINS/LESION	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
37760	LIGATE LEG VEINS RADICAL	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
37761	LIGATE LEG VEINS OPEN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
37765	STAB PHLEB VEINS XTR 10-20	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
37766	PHLEB VEINS - EXTREM 20+	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
37780	REVISION OF LEG VEIN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
37785	LIGATE/DIVIDE/EXCISE VEIN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–

37790	PENILE VENOUS OCCLUSION	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
37799	UNLISTED PX VASCULAR SURGERY	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
38129	UNLISTED LAPS PX SPLEEN	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
38204	BL DONOR SEARCH MANAGEMENT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
38205	HARVEST ALLOGENEIC STEM CELL	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
38206	HARVEST AUTO STEM CELLS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, and may require Prior Authorization per contract agreement.	–	–	–
38207	CRYOPRESERVE STEM CELLS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
38208	THAW PRESERVED STEM CELLS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
38209	WASH HARVEST STEM CELLS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
38210	T-CELL DEPLETION OF HARVEST	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
38211	TUMOR CELL DEplete OF HARVST	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
38212	RBC DEPLETION OF HARVEST	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
38213	PLATELET DEplete OF HARVEST	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–

38214	VOLUME DEplete OF HARVEST	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
38215	HARVEST STEM CELL CONCENTRTE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
38230	BONE MARROW HARVEST ALLOGEN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, and may require Prior Authorization per contract agreement.	–	–	–
38232	BONE MARROW HARVEST AUTOLOG	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
38240	TRANSPLT ALLO HCT/DONOR	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
38241	TRANSPLT AUTOL HCT/DONOR	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, and may require Prior Authorization per contract agreement.	–	–	–
38242	TRANSPLT ALLO LYMPHOCYTES	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
38243	TRANSPLJ HEMATOPOIETIC BOOST	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
38308	INCISION OF LYMPH CHANNELS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
38589	UNLISTED LAPS PX LYMPHTC SYS	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
38999	UNLISTD PX HEMIC/LYMPHTC SYS	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
39499	UNLISTED PX MEDIASTINUM	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
39599	UNLISTED PX DIAPHRAGM	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–

40799	UNLISTED PROCEDURE LIPS	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
40899	UNLISTED PX VESTIBULE MOUTH	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
41512	TONGUE SUSPENSION	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
41530	TONGUE BASE VOL REDUCTION	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
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 to avoid post-service review.	–	–	–
42145	REPAIR PALATE PHARYNX/UVULA	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review 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.	–	–	–
43206	ESOPH OPTICAL ENDOMICROSCOPY	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
43210	EGD ESOPHAGOGASTRC FNDOPSTY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review 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 to avoid post-service review.	–	–	–
43252	EGD OPTICAL ENDOMICROSCOPY	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
43257	EGD W/THRML TXMNT GERD	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
43284	LAPS ESOPHGL SPHNCTR AGMNTJ	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
43289	UNLISTED LAPS PX ESOPH	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.; Procedures/services not specifically defined or classified, maybe subject to contract/clinical 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: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	1/1/2023	–	–
43291	EGD FLX TRNSORL RMVL BALO	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	1/1/2023	–	–
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 to avoid post-service review.	6/1/2023	–	–
43633	REMOVAL OF STOMACH PARTIAL	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
43644	LAP GASTRIC BYPASS/ROUX-EN-Y	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–

43645	LAP GASTR BYPASS INCL SMALL I	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
43659	UNLISTED LAPS PX STOMACH	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	—	—	—
43770	LAP PLACE GASTR ADJ DEVICE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
43771	LAP REVISE GASTR ADJ DEVICE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
43772	LAP RMVL GASTR ADJ DEVICE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review 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 to avoid post-service review.	—	—	—
43774	LAP RMVL GASTR ADJ ALL PARTS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
43775	LAP SLEEVE GASTRECTOMY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
43842	V-BAND GASTROPLASTY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
43843	GASTROPLASTY W/O V-BAND	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
43845	GASTROPLASTY DUODENAL SWITCH	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
43846	GASTRIC BYPASS FOR OBESITY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
43847	GASTRIC BYPASS INCL SMALL I	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—

43848	REVISION GASTROPLASTY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
43886	REVISE GASTRIC PORT OPEN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
43887	REMOVE GASTRIC PORT OPEN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
43888	CHANGE GASTRIC PORT OPEN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
43999	UNLISTED PROCEDURE STOMACH	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
44238	UNLISTED LAPS PX INTESTINE	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
44705	PREPARE FECAL MICROBIOTA	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review 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: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
46999	UNLISTED PROCEDURE ANUS	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
47370	LAPARO ABLATE LIVER TUMOR RF	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
47371	LAPARO ABLATE LIVER CRYOSURG	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
47379	UNLISTED LAPS PX LIVER	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
47380	OPEN ABLATE LIVER TUMOR RF	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
47382	PERCUT ABLATE LIVER RF	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
47383	PERQ ABLTJ LVR CRYOABLATION	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
47399	UNLISTED PROCEDURE LIVER	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
47579	UNLISTED LAPS PX BILIARY TRC	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
47999	UNLISTED PX BILIARY TRACT	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
48999	UNLISTED PROCEDURE PANCREAS	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
49329	UNLSTD LAPS PX ABD PERTM&OMN	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–

49659	UNLSTD LAPS PX HRNAP HRNRPHY	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
49999	UNLISTED PX ABD PERTM&OMN	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
50250	CRYOABLATE RENAL MASS OPEN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
50360	TRANSPLANTATION OF KIDNEY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
50541	LAPARO ABLATE RENAL CYST	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
50542	LAPARO ABLATE RENAL MASS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
50549	UNLISTED LAPS PX RENAL	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
50592	PERC RF ABLATE RENAL TUMOR	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
50593	PERC CRYO ABLATE RENAL TUM	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
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 to avoid post-service review.	–	–	–
51999	UNLISTED LAPS PX BLADDER	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
52327	CYSTOSCOPY INJECT MATERIAL	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–

52441	CYSTOURETHRO W/IMPLANT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
52442	CYSTOURETHRO W/ADDL IMPLANT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
53855	INSERT PROST URETHRAL STENT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	5/14/2024	Retire effective 05/14/2024
53860	TRANSURETHRAL RF TREATMENT	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
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 to avoid post-service review.	–	–	–
54200	TREATMENT OF PENIS LESION	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
54205	TREATMENT OF PENIS LESION	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
54240	PENIS STUDY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
54400	INSERT SEMI-RIGID PROSTHESIS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
54401	INSERT SELF-CONTD PROSTHESIS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
54405	INSERT MULTI-COMP PENIS PROS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
54406	REMOVE MUTI-COMP PENIS PROS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review 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 to avoid post-service review.	–	–	–
54410	REMOVE/REPLACE PENIS PROSTH	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review 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 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 to avoid post-service review.	–	–	–
54416	REMOV/REPL PENIS CONTAIN PROS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
54417	REMOV/REPLC PENIS PROS COMPL	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
54660	REVISION OF TESTIS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
54699	UNLISTED LAPS PX TESTIS	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
55559	UNLSTD LAPS PX SPRMATIC CORD	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
55706	PROSTATE SATURATION SAMPLING	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
55873	CRYOABLATE PROSTATE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
55880	ABLTY MAL PRST8 TISS HIFU	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–

55899	UNLISTED PX MALE GENITAL SYS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.; Procedures/services not specifically defined or classified, maybe subject to contract/clinical 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 to avoid post-service review.	—	—	—
55980	SEX TRANSFORMATION F TO M	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
56805	REPAIR CLITORIS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
56810	REPAIR OF PERINEUM	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
57291	CONSTRUCTION OF VAGINA	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
57292	CONSTRUCT VAGINA WITH GRAFT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
57296	REVISE VAG GRAFT OPEN ABD	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
57335	REPAIR VAGINA	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review 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 to avoid post-service review.	—	—	—
58321	ARTIFICIAL INSEMINATION	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	—	—	—
58322	ARTIFICIAL INSEMINATION	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	—	—	—

58323	SPERM WASHING	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
58578	UNLISTED LAPS PX UTERUS	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
58579	UNLISTED HYSTSC PX UTERUS	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
58679	UNLISTED LAPS PX OVIDCT OVRY	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
58750	REPAIR OVIDUCT	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.	–	–	–
59074	FETAL FLUID DRAINAGE W/US	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
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 to avoid post-service review.; Procedures/services not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
60699	UNLISTED PX ENDOCRINE SYSTEM	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–

61630	INTRACRANIAL ANGIOPLASTY	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
61635	INTRACRAN ANGIOPLSTY W/STENT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review 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 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 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 to avoid post-service review.	–	–	–
62263	EPIDURAL LYSIS MULT SESSIONS	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
62264	EPIDURAL LYSIS ON SINGLE DAY	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
62287	DCMPRN PX PERQ 1/MLT LUMBAR	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
64555	IMPLANT NEUROELECTRODES	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review 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 to avoid post-service review.	–	–	–
64575	OPN IMPLTJ NEA PERPH NERVE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
64582	OPN MPLTJ HPGLSL NSTM ARY PG	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, and may require Prior Authorization per contract agreement.	–	–	–
64590	INSRT/REDO PN/GASTR STIMUL	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–

64628	TRML DSTRJ IOS BVN 1ST 2 L/S	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
64629	TRML DSTRJ IOS BVN EA ADDL	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
64640	INJECTION TREATMENT OF NERVE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
64809	REMOVE SYMPATHETIC NERVES	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
64999	UNLISTED PX NERVOUS SYSTEM	Unlisted Procedure; May require Prior Authorization per contract agreement.	–	–	–
65760	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 to avoid post-service review.	–	–	–
65770	REVISE CORNEA WITH IMPLANT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
65772	CORRECTION OF ASTIGMATISM	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
65775	CORRECTION OF ASTIGMATISM	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
65785	IMPLTJ NTRSTRML CRNL RNG SEG	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
66174	TRLUML DIL AQ O/F CAN W/O ST	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
66175	TRLUML DIL AQ O/F CAN W/ST	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
66179	AQUEOUS SHUNT EYE W/O GRAFT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–

66180	AQUEOUS SHUNT EYE W/GRAFT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
66183	INSERT ANT DRAINAGE DEVICE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review 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 to avoid post-service review.	–	–	–
66991	XCAPSL CTRC RMVL INSJ 1+	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
66999	UNLISTED PX ANT SEGMENT EYE	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
67299	UNLISTED PX POSTERIOR SEGMNT	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
67399	UNLISTED PX EXTRAOCULAR MUSC	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
67599	UNLISTED PROCEDURE ORBIT	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
67900	REPAIR BROW DEFECT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, and may require Prior Authorization per contract agreement.	–	2/14/2024	Retire effective 02/14/2024
67901	REPAIR EYELID DEFECT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
67902	REPAIR EYELID DEFECT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
67903	REPAIR EYELID DEFECT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
67904	REPAIR EYELID DEFECT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–

67906	REPAIR EYELID DEFECT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
67908	REPAIR EYELID DEFECT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
67999	UNLISTED PROCEDURE EYELIDS	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
68399	UNLISTED PX CONJUNCTIVA	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
68899	UNLISTED PX LACRIMAL SYSTEM	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
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 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 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 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 to avoid post-service review.	–	–	–
69719	RPLCM OI IMPLT SK TC ESP<100	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
69728	RMV NTR OI IMP SK TC>=100	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2023	–	–
69729	IMPL OI IMPLT SK TC ESP>=100	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2023	–	–

69730	RPLC OI IMPLT SK TC ESP>=100	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2023	–	–
69799	UNLISTED PX MIDDLE EAR	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical 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.	–	–	–
76120	CINE/VIDEO X-RAYS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review 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 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 to avoid post-service review.	–	–	–
76999	ECHO EXAMINATION PROCEDURE	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
77299	UNLISTED PX THER RAD TX PLNG	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–

77399	UNLISTED PX MED RADJ PHYSICS	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	—	—	—
77499	UNLISTED PX THER RAD TX MGMT	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	—	—	—
77799	UNLISTED PX CLIN BRACHYTX	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	—	—	—
78099	UNLISTED ENDOCRINE PX DX NUC	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	—	—	—
78199	UNLSTD HEMATOP RET/ENDO LYMP	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	—	—	—
78299	UNLISTED GI PX DX NUC MED	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	—	—	—
78399	UNLISTED MUSCSKEL PX DX NUC	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	—	—	—
78499	UNLISTED CV PX DX NUC MED	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	—	—	—
78599	UNLISTED RESP PX DX NUC MED	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	—	—	—
78699	UNLISTED NRVS SYS PX DX NUC	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	—	—	—
78799	UNLISTED GU PX DX NUC MED	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	—	—	—
78999	UNLISTED MISC PX DX NUC MED	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	—	—	—
79999	RP THERAPY UNLISTED PX	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	—	—	—

80299	QUANTITATIVE ASSAY DRUG	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
81099	UNLISTED URINALYSIS PX	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
81479	UNLISTED MOLECULAR PATHOLOGY	Unlisted Procedure; May require Prior Authorization per contract agreement.	–	–	–
81599	UNLISTED MAAA	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
82523	COLLAGEN CROSSLINKS	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
83695	ASSAY OF LIPOPROTEIN(A)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
83698	ASSAY LIPOPROTEIN PLA2	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
83701	LIPOPROTEIN BLD HR FRACTION	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
83704	LIPOPROTEIN BLD QUAN PART	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
83722	LIPOPRTN DIR MEAS SD LDL CHL	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
83987	EXHALED BREATH CONDENSATE	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
84112	EVAL AMNIOTIC FLUID PROTEIN	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
84999	UNLISTED CHEMISTRY PROCEDURE	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
85999	UNLISTED HEMATOLOGY&COAGJ PX	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
86001	ALLERGEN SPECIFIC IGG	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
86353	LYMPHOCYTE TRANSFORMATION	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–

86486	SKIN TEST UNLISTED ANTIGN EA	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
86849	IMMUNOLOGY PROCEDURE	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
86910	BLOOD TYPING PATERNITY TEST	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
86911	BLOOD TYPING ANTIGEN SYSTEM	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
86999	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 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 to avoid post-service review.	–	–	–
87507	IADNA-DNA/RNA PROBE TQ 12-25	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
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.	–	–	–
88045	CORONERS AUTOPSY (NECROPSY)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
88099	UNLISTED NECROPSY (AUTOPSY)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
88099	UNLISTED NECROPSY (AUTOPSY)	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
88199	UNLISTED CYTOPATHOLOGY PX	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
88299	UNLISTED CYTOGENETIC STUDY	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
88375	OPTICAL ENDOMICROSCOPY INTERP	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–

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.	—	—	—
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.	—	—	—
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 CRYOPRESERVED EMBRYO	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	—	—	—
89353	THAWING CRYOPRESERVED SPERM	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	—	—	—
89354	THAW CRYOPRESERVED REPROD TISS	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	—	—	—
89356	THAWING CRYOPRESERVED 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.	—	—	—
90378	RSV MAB IM 50MG	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, and may require Prior Authorization per contract agreement.	—	—	—

90399	UNLISTED IMMUNE GLOBULIN	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
90666	FLU VAC PANDEM PRSRV FREE IM	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
90667	IIV VACC PANDEMIC ADJUVT IM	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
90668	IIV VACCINE PANDEMIC IM	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
90749	UNLISTED VACCINE/TOXOID	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
90867	TCRANIAL MAGN STIM TX PLAN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
90868	TCRANIAL MAGN STIM TX DELI	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
90869	TCRAN MAGN STIM REDETERMINE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
90870	ELECTROCONVULSIVE THERAPY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	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 to avoid post-service review.	–	–	–
90876	PSYCHOPHYSIOLOGICAL THERAPY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
90880	HYPNOTHERAPY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
90885	PSY EVALUATION OF RECORDS	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
90889	PREPARATION OF REPORT	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
90899	UNLISTED PSYC SVC/THERAPY	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–

90901	BIOFEEDBACK TRAIN ANY METH	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review 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 to avoid post-service review.	–	–	–
90913	BFB TRAINING EA ADDL 15 MIN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
90999	UNLISTED DIALYSIS PROCEDURE	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
91110	GI TRC IMG INTRAL ESOPH-ILE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
91113	GI TRC IMG INTRAL COLON I&R	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	1/1/2023	–	–
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	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
92145	CORNEAL HYSTERESIS DETER	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
92499	UNLISTED OPH SVC/PROCEDURE	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
92548	CDP-SOT 6 COND W/I&R	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
92549	CDP-SOT 6 COND W/I&R MCT&ADT	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
92700	UNLISTED ORL SERVICE/PX	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
93228	REMOTE 30 DAY ECG REV/REPORT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
93229	REMOTE 30 DAY ECG TECH SUPP	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–

93264	REM MNTR WRLS P-ART PRS SNR	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
93580	TRANSCATH CLOSURE OF ASD	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
93660	TILT TABLE EVALUATION	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
93799	UNLISTED CV SVC/PROCEDURE	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
93998	UNLISTD NONINVAS VASC DX STD	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
94014	PATIENT RECORDED SPIROMETRY	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
94015	PATIENT RECORDED SPIROMETRY	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
94016	REVIEW PATIENT SPIROMETRY	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
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.	–	–	–
94799	UNLISTED PULMONARY SVC/PX	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
95199	UNLISTED ALL/IMMLG SVC/PX	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
95803	ACTIGRAPHY TESTING	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
95919	QUAN PUPLMTRY PHY/QHP UNI/BI	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	1/1/2023	–	–

95965	MEG SPONTANEOUS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
95966	MEG EVOKED SINGLE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
95967	MEG EVOKED EACH ADDL	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
95981	IO ANAL GAST N-STIM SUBSQ	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
95982	IO GA N-STIM SUBSQ W/REPROG	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
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 to avoid post-service review.	–	–	–
96001	MOTION TEST W/FT PRESS MEAS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
96002	DYNAMIC SURFACE EMG	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
96003	DYNAMIC FINE WIRE EMG	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
96004	PHYS REVIEW OF MOTION TESTS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
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.	–	–	–

96571	PHOTODYNAMIC TX ADDL 15 MIN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
96912	PHOTOCHEMOTHERAPY WITH UV-A	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
96913	PHOTOCHEMOTHERAPY UV-A OR B	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
96999	UNLISTED SPEC DERM SVC/PX	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
97039	UNLISTED MODALITY	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
97139	UNLISTED THERAPEUTIC PX	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
97799	UNLISTED PHYSCL MED/REHAB PX	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
97810	ACUPUNCT W/O STIMUL 15 MIN	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
97811	ACUPUNCT W/O STIMUL ADDL 15M	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
97813	ACUPUNCT W/STIMUL 15 MIN	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
97814	ACUPUNCT W/STIMUL ADDL 15M	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
99026	IN-HOSPITAL ON CALL SERVICE	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
99027	OUT-OF-HOSP ON CALL SERVICE	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
99050	MEDICAL SERVICES AFTER HRS	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
99056	MED SERVICE OUT OF OFFICE	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–

99058	OFFICE EMERGENCY CARE	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	—	—	—
99070	SPECIAL SUPPLIES PHYS/QHP	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	—	—	—
99071	PATIENT EDUCATION MATERIALS	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	—	—	—
99075	MEDICAL TESTIMONY	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	—	—	—
99075	MEDICAL TESTIMONY	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.	—	—	—
99080	SPECIAL REPORTS OR FORMS	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.	—	—	—
99082	UNUSUAL PHYSICIAN TRAVEL	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	—	—	—
99175	INDUCTION OF VOMITING	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	—	—	—
99199	UNLISTED SPECIAL SVC PX/RPRT	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	—	—	—
99360	PHYSICIAN STANDBY SERVICES	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	—	—	—
99429	UNLISTED PREVENTIVE SERVICE	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	—	—	—
99450	BASIC LIFE DISABILITY EXAM	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	—	—	—
99455	WORK RELATED DISABILITY EXAM	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	—	—	—

99456	DISABILITY EXAMINATION	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
99499	UNLISTED E&M SERVICE	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
99509	HOME VISIT DAY LIFE ACTIVITY	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
99600	UNLISTED HOME VISIT SVC/PX	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
0052U	LPOPRTN BLD W/5 MAJ CLASSES	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
0054T	BONE SRGRY CMPTR FLUOR IMAGE	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
0055T	BONE SRGRY CMPTR CT/MRI IMAG	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
0062U	AI SLE IGG&IGM ALYS 80 BMRK	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
0075T	PERQ STENT/CHEST VERT ART	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
0076T	S&I STENT/CHEST VERT ART	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
0200T	PERQ SACRAL AUGMT UNILAT INJ	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review 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 to avoid post-service review.	–	–	–
0202T	POST VERT ARTHRPLST 1 LUMBAR	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
0219T	PLMT POST FACET IMPLT CERV	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–

0220T	PLMT POST FACET IMPLT THOR	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
0221T	PLMT POST FACET IMPLT LUMB	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
0222T	PLMT POST FACET IMPLT ADDL	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
0232T	NJX PLATELET PLASMA	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
0253T	INSERT AQUEOUS DRAIN DEVICE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
0263T	IM B1 MRW CEL THER CMPL	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
0264T	IM B1 MRW CEL THER XCL HRVST	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
0265T	IM B1 MRW CEL THER HRVST ONL	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
0266T	IMPLT/RPL CRTD SNS DEV TOTAL	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
0267T	IMPLT/RPL CRTD SNS DEV LEAD	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
0268T	IMPLT/RPL CRTD SNS DEV GEN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
0269T	REV/REML CRTD SNS DEV TOTAL	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
0270T	REV/REML CRTD SNS DEV LEAD	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
0271T	REV/REML CRTD SNS DEV GEN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–

0272T	INTERROGATE CRTD SNS DEV	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review 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 to avoid post-service review.	–	–	–
0274T	PERQ LAMOT/LAM CRV/THRC	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
0275T	PERQ LAMOT/LAM LUMBAR	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
0308T	INSJ OCULAR TELESCOPE PROSTH	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
0331T	HEART SYMP IMAGE PLNR	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review 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 to avoid post-service review.	–	–	–
0335T	INSJ SINUS TARSI IMPLANT	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
0338T	TRNSCTH RENAL SYMP DENRV UNL	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
0339T	TRNSCTH RENAL SYMP DENRV BIL	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
0345T	TRANSCATH MTRAL VLVE REPAIR	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
0352T	OCT BRST/NODE I&R PER SPEC	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
0354T	OCT BREAST SURG CAVITY I&R	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–

0397T	ERCP W/OPTICAL ENDOMICROSCPY	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
0398T	MGRFUS STRTCTC LES ABLTJ	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review 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 to avoid post-service review.	–	–	–
0422T	TACTILE BREAST IMG UNI/BI	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
0424T	INSJ/RPLC NSTIM APNEA COMPL	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	12/31/2023	Retire effective 12/31/2023
0425T	INSJ/RPLC NSTIM APNEA SEN LD	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	12/31/2023	Retire effective 12/31/2023
0426T	INSJ/RPLC NSTIM APNEA STM LD	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	12/31/2023	Retire effective 12/31/2023
0427T	INSJ/RPLC NSTIM APNEA PLS GN	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	12/31/2023	Retire effective 12/31/2023
0428T	RMVL NSTIM APNEA PLS GEN	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	12/31/2023	Retire effective 12/31/2023
0429T	RMVL NSTIM APNEA SEN LD	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	12/31/2023	Retire effective 12/31/2023
0430T	RMVL NSTIM APNEA STIMJ LD	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	12/31/2023	Retire effective 12/31/2023
0431T	RMVL/RPLC NSTIM APNEA PLS GN	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	12/31/2023	Retire effective 12/31/2023
0432T	REPOS NSTIM APNEA STIMJ LD	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	12/31/2023	Retire effective 12/31/2023

0433T	REPOS NSTIM APNEA SENSING LD	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	12/31/2023	Retire effective 12/31/2023
0434T	INTERRO EVAL NPGS APNEA	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	12/31/2023	Retire effective 12/31/2023
0435T	PRGRMG EVAL NPGS APNEA 1 SES	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	12/31/2023	Retire effective 12/31/2023
0436T	PRGRMG EVAL NPGS APNEA STUDY	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	12/31/2023	Retire effective 12/31/2023
0449T	INSJ AQUEOUS DRAIN DEV 1ST	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
0450T	INSJ AQUEOUS DRAIN DEV EACH	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
0465T	SUPCHRD L NJX RX W/O SUPPLY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	12/31/2023	Retire effective 12/31/2023
0474T	INSJ AQUEOUS DRG DEV IO RSVR	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
0479T	FXJL ABL LSR 1ST 100 SQ CM	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
0480T	FXJL ABL LSR EA ADDL 100SQCM	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
0483T	TMVI PERCUTANEOUS APPROACH	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
0484T	TMVI TRANSTHORACIC EXPOSURE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
0494T	PREP & CANNULJ CDVR DON LUNG	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review 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 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 to avoid post-service review.	–	–	–
0499T	CYSTO F/URL STRIX/STENOSIS	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	12/31/2023	Retire effective 12/31/2023
0511T	RMVL&RINSJ SINUS TARSI IMPLT	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
0516T	INSJ WCS LV ELTRD ONLY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review 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 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 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 to avoid post-service review.	–	–	–
0533T	CONT REC MVMT DO 6-10 DAYS	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	12/31/2023	Retire effective 12/31/2023
0534T	CONT REC MVMT DO SETUP&TRAIN	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	12/31/2023	Retire effective 12/31/2023
0535T	CONT REC MVMT DO REPT CNFIG	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	12/31/2023	Retire effective 12/31/2023
0536T	CONT REC MVMT DO DL W/I&R	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	12/31/2023	Retire effective 12/31/2023
0537T	BLD DRV T LYMPHCYT CAR-T CLL	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/15/2023	–	–

0538T	BLD DRV T LYMPHCYT PREP TRNS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/15/2023	–	–
0539T	RECEIPT&PREP CAR-T CLL ADMN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/15/2023	–	–
0540T	CAR-T CLL ADMN AUTOLOGOUS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/15/2023	–	–
0544T	TCAT MV ANNULUS RCNSTJ	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
0552T	LOW-LEVEL LASER THERAPY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
0565T	AUTOL CELL IMPLT ADPS HRVG	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
0566T	AUTOL CELL IMPLT ADPS NJX	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
0587T	PERQ IMPLTJ/RPLCMT ISDNS PTN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
0588T	REVISION/REMOVAL ISDNS PTN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
0589T	ELEC ALYS SMPL PRGRMG IINS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
0590T	ELEC ALYS CPLX PRGRMG IINS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
0602T	TRANSDERMAL GFR MEASUREMENTS	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
0603T	TRANSDERMAL GFR MONITORING	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–

0615T	EYE MVMT ALYS W/O CALBRJ I&R	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
0620T	EVASC VEN ARTLZ TIBL/PRNL VN	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
0621T	TRABECULOSTOMY INTERNO LASER	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
0622T	TRABECULOSTOMY INT LSR W/SCP	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
0623T	AUTO QUANTIFICATION C PLAQUE	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
0624T	AUTO QUAN C PLAQ DATA PREP	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
0625T	AUTO QUAN C PLAQ CPTR ALYS	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
0626T	AUTO QUAN C PLAQ I&R	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
0627T	PERQ NJX ALGC FLUOR LMBR 1ST	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
0628T	PERQ NJX ALGC FLUOR LMBR EA	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
0629T	PERQ NJX ALGC CT LMBR 1ST	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
0630T	PERQ NJX ALGC CT LMBR EA	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
0631T	TC VIS LIT HYPERSPECTRAL IMG	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–

0632T	PERQ TCAT US ABLTJ NRV P-ART	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	—	—
0639T	WRLS SKN SNR ANISOTROPY MEAS	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	—	—	—
0640T	NCNTC NR IFR SPCTRSC WND	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	—	—	—
0641T	NCNTC NR IFR SPCTRSC WND IMG	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	—	12/31/2023	Retire effective 12/31/2023
0642T	NCNTC NR IFR SPCTRSC WND I&R	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	—	12/31/2023	Retire effective 12/31/2023
0643T	TCAT L VENTR RSTRJ DEV IMPLT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
0645T	TCAT IMPLTJ C SINS RDCTJ DEV	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
0646T	TTVI/RPLCMT W/PRSTC VLV PERQ	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
0650T	PRGRMG DEV EVAL SCRMS REMOTE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
0651T	MAG CTRLD CAPSULE ENDOSCOPY	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	1/1/2023	—	—
0656T	VRT BDY TETHERING ANT <7 SEG	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	—	—	—
0657T	VRT BDY TETHERING ANT 8+ SEG	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	—	—	—
0664T	DON HYSTERECTOMY OPEN CDVR	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	—	—	—

0665T	DON HYSTERECTOMY OPEN LIV	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
0666T	DON HYSTERECTOMY LAPS LIV	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
0667T	DON HYSTERECTOMY RCP UTER	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
0668T	BKBENCH PREP DON UTER ALGRFT	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
0669T	BKBENCH RCNSTJ DON UTER VEN	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
0670T	BKBENCH RCNSTJ DON UTER ARTL	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
0672T	NDOVAG CRYG RF REMDL TISS	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
0743T	B1 STR & FX RSK VRT FX ASSMT	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	1/1/2023	–	–
0744T	Insj Bioprostc Vlv Fem Vn	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	9/1/2023	–	–
0745T	Car Ablt Rad Arr N-Invas Loc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/15/2023	–	–
0746T	Car Ablt Rad Arr Cnv Loc Map	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/15/2023	–	–
0747T	Car Ablt Rad Arrhyt Dlvr Rad	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/15/2023	–	–
0748T	Njx Stm Cl Prdct Anl Sft Tis	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	9/1/2023	–	–

0748T	NJX STM CL PRDCT ANL SFT TIS	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	9/1/2023	–	–
0764T	Asstv Alg Ecg Rsk Asmt Cncrt	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/15/2023	–	–
0765T	Asstv Alg Ecg Rsk Asmt Prev	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/15/2023	–	–
0766T	Tc Mag Stimj Pn 1St Tx 1Nrv	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	7/1/2023	–	–
0767T	Tc Mag Stimj Pn 1St Tx Ea	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	7/1/2023	–	–
0768T	Tc Mag Stimj Pn Sbsq Tx 1Nrv	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	7/1/2023	12/31/2023	Retire effective 12/31/2023
0769T	Tc Mag Stimj Pn Sbsq Tx Ea	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	7/1/2023	12/31/2023	Retire effective 12/31/2023
0770T	Vr Technology Assist Therapy	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	9/1/2023	–	–
0771T	VR PX DISSOC SVC SM PHY 1ST	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	9/1/2023	–	–
0772T	Vr Px Dissoc Svc Sm Phy Ea	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	9/1/2023	–	–
0773T	VR PX DISSOC SVC OTH PHY 1ST	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	9/1/2023	–	–
0774T	VR PX DISSOC SVC OTH PHY EA	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	9/1/2023	–	–
0775T	ARTHRD SI JT PRQ IARTIC IMPL	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	1/1/2023	12/31/2023	Retire effective 12/31/2023

0776T	THER INDCTJ NTRABRN HYPTHRM	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	9/1/2023	–	–
0777T	R-T PRS SENSING EDRL GDN SYS	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	9/1/2023	–	–
0778T	SMMG CNCRNT APPL IMU SNR	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	9/1/2023	–	–
0779T	GI MYOELECTRICAL ACTV STUDY	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	9/1/2023	–	–
0780T	INSTLJ FECAL MICROBIOTA SSP	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2023	–	–
0781T	BRNCHSC RF DSTRJ PULM NRV BI	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	9/1/2023	–	–
0782T	BRNCHSC RF DSTRJ PLM NRV UNI	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	9/1/2023	–	–
0783T	TC AURICULR NEUROSTIMULATION	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	1/1/2023	–	–
0791T	Motor-cognitive, semi-immersive virtual reality–facilitated gait training, each 15 minutes (List separately in addition to code for primary procedure)	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	7/1/2023	–	–
0793T	Percutaneous transcatheter thermal ablation of nerves innervating the pulmonary arteries, including right heart catheterization, pulmonary artery angiography, and all imaging guidance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	–	–

0795T	Transcatheter insertion of permanent dual-chamber leadless pacemaker, including imaging guidance (e.g., fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (e.g., interrogation or programming), when performed; complete system (i.e., right atrial and right ventricular pacemaker components)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	–	–
0796T	Transcatheter insertion of permanent dual-chamber leadless pacemaker, including imaging guidance (e.g., fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (e.g., interrogation or programming), when performed; right atrial pacemaker component (when an existing right ventricular single leadless pacemaker exists to create a dual-chamber leadless pacemaker system)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	–	–

0797T	Transcatheter insertion of permanent dual-chamber leadless pacemaker, including imaging guidance (e.g., fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (e.g., interrogation or programming), when performed; right ventricular pacemaker component (when part of a dual-chamber leadless pacemaker system)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	–	–
0798T	Transcatheter removal of permanent dual-chamber leadless pacemaker, including imaging guidance (e.g., fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography), when performed; complete system (i.e., right atrial and right ventricular pacemaker components)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	–	–
0799T	Transcatheter removal of permanent dual-chamber leadless pacemaker, including imaging guidance (e.g., fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography), when performed; right atrial pacemaker component	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	–	–

0800T	Transcatheter removal of permanent dual-chamber leadless pacemaker, including imaging guidance (e.g., fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography), when performed; right ventricular pacemaker component (when part of a dual-chamber leadless pacemaker system)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	–	–
0801T	Transcatheter removal and replacement of permanent dual-chamber leadless pacemaker, including imaging guidance (e.g., fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (e.g., interrogation or programming), when performed; dual-chamber system (i.e., right atrial and right ventricular pacemaker components)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	–	–

0802T	Transcatheter removal and replacement of permanent dual-chamber leadless pacemaker, including imaging guidance (e.g., fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (e.g., interrogation or programming), when performed; right atrial pacemaker component	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	–	–
0803T	Transcatheter removal and replacement of permanent dual-chamber leadless pacemaker, including imaging guidance (e.g., fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (e.g., interrogation or programming), when performed; right ventricular pacemaker component (when part of a dual-chamber leadless pacemaker system)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	–	–

0804T	Programming device evaluation (in person) with iterative adjustment of implantable device to test the function of device and to select optimal permanent programmed values, with analysis, review, and report, by a physician or other qualified health care professional, leadless pacemaker system in dual cardiac chambers	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	–	–
0805T	Transcatheter superior and inferior vena cava prosthetic valve implantation (i.e., caval valve implantation [CAVI]); percutaneous femoral vein approach	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	–	–
0806T	Transcatheter superior and inferior vena cava prosthetic valve implantation (i.e., caval valve implantation [CAVI]); open femoral vein approach	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	–	–
0807T	Pulmonary tissue ventilation analysis using software-based processing of data from separately captured cinefluorograph images; in combination with previously acquired computed tomography (CT) images, including data preparation and transmission, quantification of pulmonary tissue ventilation, data review, interpretation and report	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	7/1/2023	–	–

0808T	Pulmonary tissue ventilation analysis using software-based processing of data from separately captured cinefluorograph images; in combination with computed tomography (CT) images taken for the purpose of pulmonary tissue ventilation analysis, including data preparation and transmission, quantification of pulmonary tissue ventilation, data review, interpretation and report	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	7/1/2023	–	–
0810T	Subretinal injection of a pharmacologic agent, including vitrectomy and 1 or more retinotomies	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	–	–
A0021	Outside state ambulance serv	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-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 esctr	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.	–	–	–
A0426	Als 1	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
A0431	Rotary wing air transport	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
A0436	Rotary wing air mileage	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
A0888	Noncovered ambulance mileage	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-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: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
A2002	Mirrugen adv wnd mat per sq	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
A2004	Xcellistem 1 mg	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
A2005	Microlyte matrix per sq cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
A2006	Novosorb synpath per sq cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
A2007	Restrata per sq cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
A2008	Theragenesis per sq cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–

A2009	Symphony per sq cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
A2010	Apis per square centimeter	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
A2011	Supra sdrn per sq cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
A2012	Suprathel per sq cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
A2013	Innovamatrix fs per sq cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
A2014	Omeza collag per 100 mg	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	4/1/2023	–	–
A2015	Phoenix wnd mtrx per sq cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	4/1/2023	–	–
A2016	Permeaderm b per sq cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	4/1/2023	–	–
A2017	Permeaderm glove each	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	4/1/2023	–	–
A2018	Permeaderm c per sq cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	4/1/2023	–	–
A2019	Kerecis marigen shld sq cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	9/1/2023	–	–
A2020	Ac5 wound system	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	9/1/2023	–	–
A2021	Neomatrix per sq cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	9/1/2023	–	–

A4100	Skin sub fda clrd as dev nos	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review 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.	–	–	–
A4246	Betadine/phisoohex 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.	–	–	–
A4335	Incontinence supply	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
A4335	Incontinence supply	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
A4421	Ostomy supply misc	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
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.	–	–	–
A4458	Reusable enema bag	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
A4465	Non-elastic extremity binder	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-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.	–	–	–
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 to avoid post-service review.	–	–	–

A4558	Conductive gel or paste	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
A4596	Ces system monthly supp	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	4/1/2023	–	–
A4600	Sleeve inter limb comp dev	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
A4641	Radiopharm dx agent noc	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
A4649	Surgical supplies	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
A4890	Repair/maint cont hemo equip	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
A4913	Misc dialysis supplies noc	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
A4927	Non-sterile gloves	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
A4931	Reusable oral thermometer	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
A4932	Reusable rectal thermometer	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
A5507	Modification diabetic shoe	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
A6216	Non-sterile gauze<=16 sq in	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
A6217	Non-sterile gauze>16<=48 sq	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
A6218	Non-sterile gauze > 48 sq in	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
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.	–	–	–
A6530	Compression stocking BK18-30	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
A6531	Compression stocking BK30-40	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
A6533	Gc stocking thighlngh 18-30	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
A6534	Gc stocking thighlngh 30-40	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
A6536	Gc stocking full lngth 18-30	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
A6537	Gc stocking full lngth 30-40	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
A6539	Gc stocking waistlngh 18-30	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
A6540	Gc stocking waistlngh 30-40	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
A6544	Gc stocking garter belt	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
A6549	G compression stocking	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
A6549	G compression stocking	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
A7049	Epap nasal valve	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven. 9/1/2023	–	–	–
A9150	Misc/exper non-prescript dru	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
A9152	Single vitamin nos	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
A9152	Single vitamin nos	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
A9153	Multi-vitamin nos	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
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.	–	–	–
A9273	Hot/cold bottle/cap/col/wrap	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
A9279	Monitoring feature/deviceNOC	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
A9280	Alert device noc	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
A9282	Wig any type	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
A9285	Inversion eversion cor devic	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
A9291	Pres dig cog behav thera fda	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
A9300	Exercise equipment	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
A9579	Gad-base MR contrast NOS 1ml	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
A9597	Pet dx for tumor id noc	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
A9598	Pet dx for non-tumor id noc	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
A9698	Non-rad contrast materialNOC	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
A9699	Radiopharm rx agent noc	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
A9900	Supply/accessory/service	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
A9999	DME supply or accessory nos	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–

B4102	EF adult fluids and electro	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
B4103	EF ped fluid and electrolyte	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
B4104	Additive for enteral formula	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
B4105	Enzyme cartridge enteral nut	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
B4149	EF blenderized foods	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
B4150	EF complet w/intact nutrient	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
B4152	EF calorie dense \geq 1.5Kcal	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
B4154	EF spec metabolic noninherit	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
B4158	EF ped complete intact nut	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
B4159	EF ped complete soy based	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
B4160	EF ped caloric dense \geq 0.7kc	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
B4164	Parenteral 50% dextrose solu	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-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: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
C1761	Cath trans intra litho/coro	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
C1764	Event recorder cardiac	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–

C1776	Joint device (implantable)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
C1783	Ocular imp aqueous drain de	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
C1817	Septal defect imp sys	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
C1818	Integrated keratoprosthesis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
C1822	Gen neuro hf rechg bat	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
C1823	Gen neuro trans sen/stim	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
C1825	Gen neuro carot sinus baro	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
C1826	Gen neuro clo loop rechg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	–	–
C1827	Gen, Neuro, Imp Led, Ex Cntr	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	9/1/2023	–	–
C1833	Cardiac monitor sys	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
C1889	Implant/insert device noc	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
C2623	Cath translumin drug-coat	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
C2624	Wireless pressure sensor	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–

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 to avoid post-service review.	4/1/2023	–	–
C5272	Low cost skin substitute app	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2023	–	–
C5273	Low cost skin substitute app	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2023	–	–
C5274	Low cost skin substitute app	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2023	–	–
C5275	Low cost skin substitute app	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2023	–	–
C5276	Low cost skin substitute app	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2023	–	–
C5277	Low cost skin substitute app	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2023	–	–
C5278	Low cost skin substitute app	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2023	–	–
C9257	Bevacizumab injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, and may require Prior Authorization per contract agreement.	–	–	–
C9354	Veritas collagen matrix cm2	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
C9356	TenoGlide tendon prot cm2	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–

C9358	Dermal substitute native non-denatured collagen fetal bovine origin (SurgiMend Collagen Matrix) per 0.5 square centimeters	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
C9360	SurgiMend neonatal	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
C9363	Integra Meshed Bil Wound Mat	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
C9364	Porcine implant Permacol	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
C9399	unclassified drugs or biologicals	Unlisted Procedure; May require Prior Authorization per contract agreement.	–	–	–
C9734	U/S trtmt not leiomyomata	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
C9739	Cystoscopy prostatic imp 1-3	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
C9740	Cysto impl 4 or more	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
C9757	Spine/lumbar disk surgery	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
C9764	Revasc intravasc lithotripsy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
C9765	Revasc intra lithotrip-stent	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
C9766	Revasc intra lithotrip-ather	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
C9767	Revasc lithotrip-stent-ather	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–

C9768	Endo us-guide hep porto grad	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
C9769	Cysto w/temp pros implant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
C9770	Vitrec/mech pars subret inj	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	12/31/2023	Retire effective 12/31/2023
C9771	Nsl/sins cryo post nasal tis	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	12/31/2023	Retire effective 12/31/2023
C9772	Revasc lithotrip tibi/perone	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
C9773	Revasc lithotr-stent tib/per	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
C9774	Revasc lithotr-ather tib/per	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
C9775	Revasc lith-sten-ath tib/per	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
C9777	Esophag muc integ w/eso egd	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
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.	–	–	–
D0999	unspecified diagnostic procedure by report	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
D1999	unspecified preventive procedure by report	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–

D2999	unspecified restorative procedure by report	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
D3410	apicoectomy - anterior	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
D3999	unspecified endodontic procedure by report	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
D4999	unspecified periodontal procedure by report	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
D5899	unspecified removable prosthodontic procedure by report	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
D5999	unspecified maxillofacial prosthesis by report	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
D6199	unspecified implant procedure by report	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
D6999	unspecified fixed prosthodontic procedure by report	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
D7210	extraction erupted tooth requiring removal of bone and/or sectioning of tooth and including elevation of mucoperiosteal flap if indicated	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
D7220	removal of impacted tooth - soft tissue	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
D7230	removal of impacted tooth - partially bony	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
D7999	unspecified oral surgery procedure by report	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
D8210	removable appliance therapy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
D8220	fixed appliance therapy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

D8999	unspecified orthodontic procedure by report	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
D9999	unspecified adjunctive procedure by report	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
E0162	Sitz bath chair	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 to avoid post-service review.	–	–	–
E0187	Water pressure mattress	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review 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.	–	–	–
E0236	Pump for water circulating p	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
E0240	Bath/shower chair	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
E0241	Bath tub wall rail	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
E0242	Bath tub rail floor	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
E0243	Toilet rail	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
E0244	Toilet seat raised	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
E0245	Tub stool or bench	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
E0246	Transfer tub rail attachment	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

E0247	Trans bench w/wo comm open	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
E0248	HDtrans bench w/wo comm open	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.	–	–	–
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.	–	–	–
E0280	Bed cradle	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
E0291	Hosp bed fx ht w/o rail w/o	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
E0293	Hosp bed var ht no sr no mat	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
E0315	Bed accessory brd/tbl/supprt	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
E0316	Bed safety enclosure	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
E0446	Topical Ox Deliver sys nos	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
E0462	Rocking bed w/ or w/o side r	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
E0485	Oral device/appliance prefab	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, and may require Prior Authorization per contract agreement.	–	–	–
E0616	Cardiac event recorder	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
E0617	Automatic ext defibrillator	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
E0620	Cap bld skin piercing laser	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

E0625	Patient lift bathroom or toi	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
E0650	Pneuma compresor non-segment	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
E0651	Pneum compressor segmental	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
E0652	Pneum compres w/cal pressure	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
E0655	Pneumatic appliance half arm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
E0656	Segmental pneumatic trunk	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
E0657	Segmental pneumatic chest	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
E0660	Pneumatic appliance full leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
E0665	Pneumatic appliance full arm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
E0666	Pneumatic appliance half leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
E0667	Seg pneumatic appl full leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
E0668	Seg pneumatic appl full arm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
E0669	Seg pneumatic appli half leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–

E0670	Seg pneum int legs/trunk	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
E0671	Pressure pneum appl full leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
E0672	Pressure pneum appl full arm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
E0673	Pressure pneum appl half leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
E0675	Pneumatic compression device	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
E0676	Inter limb compress dev NOS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.; Procedures/services not specifically defined or classified, maybe subject to contract/clinical 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 to avoid post-service review.	7/1/2023	–	–
E0691	Uvl pnl 2 sq ft or less	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
E0692	Uvl sys panel 4 ft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
E0693	Uvl sys panel 6 ft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
E0694	Uvl md cabinet sys 6 ft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
E0700	Safety equipment	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

E0746	Electromyograph biofeedback	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
E0747	Elec osteogen stim not spine	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
E0755	Electronic salivary reflex s	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
E0760	Osteogen ultrasound stim/tor	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
E0761	Nontherm electromyographic device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
E0764	Functional neuromuscular stim	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
E0766	Elec stim cancer treatment	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review 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 to avoid post-service review.	–	–	–
E0830	Ambulatory traction device	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
E0840	Tract frame attach headboard	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
E0849	Cervical pneum trac equip	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
E0850	Traction stand free standing	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
E0855	Cervical traction equipment	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
E0856	Cervic collar w air bladders	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
E0860	Tract equip cervical tract	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

E0890	Traction frame attach pelvic	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
E0920	Fracture frame attached to b	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
E0930	Fracture frame free standing	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
E0941	Gravity assisted traction de	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
E0942	Cervical head harness/halter	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
E0944	Pelvic belt/harness/boot	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
E0946	Fracture frame dual w cross	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
E0948	Fracture frame attachmnts ce	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
E0950	Tray	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
E0953	W/c lateral thigh/knee sup	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
E0954	Foot box any type each foot	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
E0955	Cushioned headrest	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
E0969	Wheelchair narrowing device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
E0981	Seat upholstery replacement	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–

E0982	Back upholstery replacement	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
E0983	Add pwr joystick	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
E0984	Add pwr tiller	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
E0985	W/c seat lift mechanism	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
E0986	Man w/c push-rim powr system	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
E0988	MANUAL WHEELCHAIR ACCESSORY LEVER-ACTIVATED WHEEL DRIVE PAIR	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
E0990	Wheelchair elevating leg res	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
E0992	Wheelchair solid seat insert	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
E1002	Pwr seat tilt	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
E1003	Pwr seat recline	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
E1004	Pwr seat recline mech	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
E1005	Pwr seat recline pwr	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review 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 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 to avoid post-service review.	—	—	—
E1008	Pwr seat combo pwr shear	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
E1009	Add mech leg elevation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
E1010	Add pwr leg elevation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
E1012	Ctr mount pwr elev leg rest	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
E1028	W/c manual swingaway	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
E1083	Hemi-wheelchair fixed arms	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
E1085	Hemi-wheelchair fixed arms	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
E1087	Wheelchair lightwt fixed arm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review 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 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 to avoid post-service review.	—	—	—
E1172	Wheelchair amputee detach ar	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review 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 to avoid post-service review.	—	—	—

E1195	Wheelchair amputee heavy dut	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
E1200	Wheelchair amputee fixed arm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
E1220	Whlchr special size/constrc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review 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 to avoid post-service review.	–	–	–
E1225	Manual semi-reclining back	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
E1226	Manual fully reclining back	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review 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 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 to avoid post-service review.	–	–	–
E1229	Pediatric wheelchair NOS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.; Procedures/services not specifically defined or classified, maybe subject to contract/clinical 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 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 to avoid post-service review.	–	–	–

E1239	Ped power wheelchair NOS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.; Procedures/services not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
E1239	Ped power wheelchair NOS	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
E1285	Wheelchair heavy duty fixed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
E1295	Wheelchair heavy duty fixed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review 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.	–	–	–
E1355	Oxygen supplies stand/rack	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.	–	–	–
E1629	Tablo for dialysis service	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
E1632	Wearable artificial kidney	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
E1699	Dialysis equipment noc	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
E1700	Jaw motion rehab system	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
E1701	Repl cushions for jaw motion	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
E1702	Repl measr scales jaw motion	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-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 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 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 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 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 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 to avoid post-service review.	—	—	—
E2211	Pneumatic propulsion tire	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
E2212	Pneumatic prop tire tube	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
E2213	Pneumatic prop tire insert	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
E2214	Pneumatic caster tire each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
E2215	Pneumatic caster tire tube	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
E2216	Foam filled propulsion tire	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review 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 to avoid post-service review.	—	—	—

E2218	Foam propulsion tire each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review 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 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 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 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 to avoid post-service review.	—	—	—
E2228	Mwc acc wheelchair brake	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
E2230	Manual standing system	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
E2231	Solid seat support base	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review 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 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 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 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 to avoid post-service review.	—	—	—
E2295	Ped dynamic seating frame	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—

E2300	Pwr seat elevation sys	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
E2301	Pwr standing	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
E2310	Electro connect btw control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
E2311	Electro connect btw 2 sys	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
E2312	Mini-prop remote joystick	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
E2313	PWC harness expand control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
E2321	Hand interface joystick	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
E2322	Mult mech switches	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
E2323	Special joystick handle	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
E2324	Chin cup interface	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
E2325	Sip and puff interface	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
E2326	Breath tube kit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
E2327	Head control interface mech	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—

E2328	Head/extremity control inter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
E2329	Head control nonproportional	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
E2330	Head control proximity switc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
E2331	Attendant control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
E2340	W/c width 20-23 in seat frame	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
E2341	W/c width 24-27 in seat frame	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review 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 to avoid post-service review.	—	—	—
E2343	W/c dpth 22-25 in seat frame	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
E2351	Electronic SGD interface	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
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 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 to avoid post-service review.	—	—	—
E2360	22nf nonsealed leadacid	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—

E2361	22nf sealed leadacid battery	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
E2362	Gr24 nonsealed leadacid	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
E2363	Gr24 sealed leadacid battery	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
E2364	U1nonsealed leadacid battery	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
E2365	U1 sealed leadacid battery	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
E2366	Battery charger single mode	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
E2367	Battery charger dual mode	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
E2371	Gr27 sealed leadacid battery	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
E2372	Gr27 non-sealed leadacid	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
E2373	Hand/chin ctrl spec joystick	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
E2374	Hand/chin ctrl std joystick	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
E2375	Non-expandable controller	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
E2376	Expandable controller repl	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–

E2377	Expandable controller initl	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
E2397	Pwc acc lith-based battery	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
E2500	SGD digitized pre-rec <=8min	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
E2502	SGD prerec msg >8min <=20min	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
E2504	SGD prerec msg>20min <=40min	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
E2506	SGD prerec msg > 40 min	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
E2508	SGD spelling phys contact	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
E2510	SGD w multi methods msg/accs	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
E2511	SGD sftwre prgrm for PC/PDA	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
E2512	SGD accessory mounting sys	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
E2599	SGD accessory noc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.; Procedures/services not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
E2599	SGD accessory noc	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–

E2601	Gen w/c cushion width < 22 in	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
E2602	Gen w/c cushion width >=22 in	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review 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 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 to avoid post-service review.	–	–	–
E2605	Position wc cush width <22 in	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
E2606	Position wc cush width>=22 in	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review 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 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 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 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 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 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 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 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 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 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 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 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 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 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 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 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 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 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 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 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 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 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 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 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 to avoid post-service review.	–	–	–
G0176	OPPS/PHP;activity therapy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
G0235	Pet imaging any site not otherwise specified	Unlisted Procedure; May require Prior Authorization per contract agreement.	–	–	–
G0276	Pild/placebo control clin tr	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
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.	–	–	–
G0341	Percutaneous islet celltrans	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
G0342	Laparoscopy islet cell trans	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
G0343	Laparotomy islet cell transp	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
G0416	Prostate biopsy any mthd	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
G0428	Collagen Meniscus Implant procedure for filling meniscal defects (e.g. CMI collagen scaffold Menaflex)	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
G0429	Dermal Filler injection(s) for the treatment of facial lipodystrophy syndrome (LDS) (e.g. as a result of highly active antiretroviral therapy.)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–

G0455	Fecal microbiota prep instil	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
G0460	Autolog prp not diab ulcer	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G0465	Autolog prp diab wound ulcer	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
G0516	insert drug del implant >=4	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review 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 to avoid post-service review.	–	–	–
G2082	Visit esketamine 56m or less	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
G2083	Visit esketamine > 56m	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
G8395	LVEF>=40% doc normal or mild	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8396	LVEF not performed	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8397	Dil macula/fundus exam/w doc	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8399	Pt w/dxa results document	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8400	Pt w/dxa no results doc	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8404	Low extremity neur exam docum	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8405	Low extremity neur not perfor	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8410	Eval on foot documented	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8415	Eval on foot not performed	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8416	Pt inelig footwear evaluatio	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G8417	Calc bmi abv up param f/u	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8418	Calc bmi blw low param f/u	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8419	Calc bmi out nrm param nof/u	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8420	Calc bmi norm parameters	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G8421	Bmi not calculated	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
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.	–	–	–
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.	–	–	–
G9012	Other Specified Case Mgmt	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
G9050	Oncology work-up evaluation	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9051	Oncology tx decision-mgmt	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9052	Onc surveillance for disease	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9053	Onc expectant management pt	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9054	Onc supervision palliative	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9055	Onc visit unspecified NOS	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9055	Onc visit unspecified NOS	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 nslc stgl no progres	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9064	Onc dx nslc stg2 no progres	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9065	Onc dx nslc stg3A no progre	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9066	Onc dx nslc stg3B-4 metasta	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9067	Onc dx nslc dx unknown nos	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9068	Onc dx sclc/nslc limited	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9069	Onc dx sclc/nslc ext at dx	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9070	Onc dx sclc/nslc ext unknwn	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9071	Onc dx brst stg1-2B HR nopro	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9072	Onc dx brst stg1-2 noprogres	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9073	Onc dx brst stg3-HR no pro	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9074	Onc dx brst stg3-noprogress	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9075	Onc dx brst metastatic/ recur	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9077	Onc dx prostate T1no progres	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9078	Onc dx prostate T2no progres	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9079	Onc dx prostate T3b-T4noprog	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9080	Onc dx prostate w/rise PSA	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9083	Onc dx prostate unknwn nos	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9084	Onc dx colon t1-3 n1-2 no pr	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G9085	Onc dx colon T4 N0 w/o prog	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9086	Onc dx colon T1-4 no dx prog	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9087	Onc dx colon metas evid dx	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9088	Onc dx colon metas noevid dx	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9089	Onc dx colon extent unknown	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9090	Onc dx rectal T1-2 no progr	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9091	Onc dx rectal T3 N0 no prog	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9092	Onc dx rectal T1-3 N1-2noprg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9093	Onc dx rectal T4 N M0 no prg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9094	Onc dx rectal M1 w/mets prog	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9095	Onc dx rectal extent unknwn	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9096	Onc dx esophag T1-T3 noprog	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9097	Onc dx esophageal T4 no prog	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9098	Onc dx esophageal mets recur	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9099	Onc dx esophageal unknown	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9100	Onc dx gastric no recurrence	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9101	Onc dx gastric p R1-R2noprog	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9102	Onc dx gastric unresectable	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9103	Onc dx gastric recurrent	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9104	Onc dx gastric unknown NOS	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G9105	Onc dx pancreatc p R0 res no	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9106	Onc dx pancreatc p R1/R2 no	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9107	Onc dx pancreatic unresectab	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9108	Onc dx pancreatic unknown 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.	–	–	–
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 Ig 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: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
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.	–	–	–
J0172	Inj aducanumab-avwa 2 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
J0202	Injection alemtuzumab	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, and may require Prior Authorization per contract agreement.	–	–	–

J0218	Inj olipudase alfa-rpcp 1mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	–	–
J0219	Inj aval alfa-nqpt 4mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, and may require Prior Authorization per contract agreement.	–	–	–
J0220	Alglucosidase alfa injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.; Procedures/services not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
J0220	Alglucosidase alfa injection	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
J0222	Inj. patisiran 0.1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, and may require Prior Authorization per contract agreement.	–	–	–
J0223	Inj givosiran 0.5 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, and may require Prior Authorization per contract agreement.	–	–	–
J0224	Inj. lumasiran 0.5 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, and may require Prior Authorization per contract agreement.	–	–	–
J0225	Inj vutrisiran 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2023	–	–
J0256	Alpha 1 proteinase inhibitor	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
J0491	Inj anifrolumab-fnia 1mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, and may require Prior Authorization per contract agreement.	–	–	–
J0517	Inj. benralizumab 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, and may require Prior Authorization per contract agreement.	–	–	–
J0565	Inj bezlotoxumab 10 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, and may require Prior Authorization per contract agreement.	–	–	–

J0567	Inj. cerliponase alfa 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, and may require Prior Authorization per contract agreement.	–	–	–
J0584	Injection burosumab-twza 1m	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, and may require Prior Authorization per contract agreement.	–	–	–
J0585	Injection onabotulinumtoxinA	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, and may require Prior Authorization per contract agreement.	–	–	–
J0587	Inj rimabotulinumtoxinB	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, and may require Prior Authorization 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, and may require Prior Authorization per contract agreement.	–	1/31/2024	Retire effective 01/31/2024
J0600	Edetate calcium disodium inj	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
J0717	Certolizumab pegol inj 1mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, and may require Prior Authorization per contract agreement.	–	–	–
J0775	Collagenase clostr hist inj	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, and may require Prior Authorization per contract agreement.	–	–	–
J0791	Inj crizanlizumab-tmca 5mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, and may require Prior Authorization per contract agreement.	–	–	–
J1301	Injection edaravone 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, and may require Prior Authorization per contract agreement.	–	–	–
J1302	Inj sutimlimab-jome 10 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, and may require Prior Authorization per contract agreement.	–	–	–
J1303	Inj. ravulizumab-cwvz 10 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, and may require Prior Authorization per contract agreement.	–	–	–

J1305	Inj evinacumab-dgnb 5mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, and may require Prior Authorization per contract agreement.	—	—	—
J1306	Injection inclisiran 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, and may require Prior Authorization per contract agreement.	—	—	—
J1325	Epoprostenol injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, and may require Prior Authorization per contract agreement.	—	—	—
J1411	Inj hemgenix per tx dose	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2023	—	—
J1426	Injection casimersen 10 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
J1427	Inj. viltolarsen	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
J1428	Inj eteplirsen 10 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, and may require Prior Authorization per contract agreement.	—	—	—
J1429	Inj golodirsen 10 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
J1551	Inj cutaquig 100 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, and may require Prior Authorization per contract agreement.	—	—	—
J1554	Inj. asceniv	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, and may require Prior Authorization 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.	—	—	—

J1632	Inj. brexanolone 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
J1675	Histrelin acetate	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, and may require Prior Authorization per contract agreement.	–	–	–
J1729	Inj hydroxyprogst capoa nos	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
J1746	Inj. ibalizumab-uiyk 10 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, and may require Prior Authorization per contract agreement.	–	–	–
J1747	Inj spesolimab-sbzo 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2023	–	–
J1823	Inj. inebilizumab-cdon 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, and may require Prior Authorization per contract agreement.	–	–	–
J1951	Inj fensolvi 0.25 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
J1954	Leuprolide depot cipla 7.5mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2023	–	–
J2278	Ziconotide injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, and may require Prior Authorization per contract agreement.	–	–	–
J2327	Inj risankizumab-rzaa 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2023	–	–
J2356	Inj tezepelumab-ekko 1mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, and may require Prior Authorization per contract agreement.	–	–	–
J2502	Inj pasireotide long acting	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, and may require Prior Authorization per contract agreement.	–	–	–
J2777	Inj faricimab-svoa 0.1mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–

J2779	Inj. susvimo 0.1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
J2787	Riboflavin 5'Phos oph<=3ml	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
J3032	Inj. eptinezumab-jjmr 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, and may require Prior Authorization per contract agreement.	–	–	–
J3121	Inj. testostero enanthate 1mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, and may require Prior Authorization per contract agreement.	–	–	–
J3145	Testosterone undecanoate 1mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, and may require Prior Authorization per contract agreement.	–	–	–
J3241	Inj. teprotumumab-trbw 10 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, and may require Prior Authorization per contract agreement.	–	–	–
J3245	Inj. tildrakizumab 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, and may require Prior Authorization per contract agreement.	–	–	–
J3299	Inj xipere 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
J3396	Verteporfin injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
J3398	Inj luxturna 1 billion vec g	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, and may require Prior Authorization per contract agreement.	–	–	–
J3399	Inj onase abepar-xioi treat	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, and may require Prior Authorization 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 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 to avoid post-service review.	–	–	–
J7178	Inj human fibrinogen con nos	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, and may require Prior Authorization 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.	–	–	–
J7311	Inj. retisert 0.01 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review 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 to avoid post-service review.	–	–	–
J7351	Inj bimatoprost itc imp1mcg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
J7599	Immunosuppressive drug noc	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–

J7699	Inhalation solution for DME	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	—	—	—
J7799	Non-inhalation drug for DME	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	—	—	—
J7999	Compounded drug noc	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	—	—	—
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.	—	—	—
J9285	Inj olaratumab 10 mg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	—	—	—
J9332	Inj efgartigimod 2mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, and may require Prior Authorization per contract agreement.	—	—	—
J9600	Porfimer sodium injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
J9999	Chemotherapy drug	Unlisted Procedure; May require Prior Authorization per contract agreement.	—	—	—

K0010	Stnd wt frame power whlchr	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
K0011	Stnd wt pwr whlchr w control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
K0012	Ltwt portbl power whlchr	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
K0013	Custom power whlchr base	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
K0014	Other power whlchr base	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
K0053	Elevate footrest articulate	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review 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 to avoid post-service review.	–	–	–
K0108	W/c component-accessory NOS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.; Procedures/services not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
K0108	W/c component-accessory NOS	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
K0455	Pump uninterrupted infusion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review 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 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 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 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 to avoid post-service review.	–	–	–
K0800	POV group 1 std up to 300lbs	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
K0801	POV group 1 hd 301-450 lbs	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
K0802	POV group 1 vhd 451-600 lbs	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
K0806	POV group 2 std up to 300lbs	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
K0807	POV group 2 hd 301-450 lbs	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
K0808	POV group 2 vhd 451-600 lbs	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
K0812	Power operated vehicle NOC	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.; Procedures/services not specifically defined or classified, maybe subject to contract/clinical 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 to avoid post-service review.	–	–	–

K0814	PWC gp 1 std port cap chair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
K0815	PWC gp 1 std seat/back	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
K0816	PWC gp 1 std cap chair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
K0820	PWC gp 2 std port seat/back	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
K0821	PWC gp 2 std port cap chair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
K0822	PWC gp 2 std seat/back	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
K0823	PWC gp 2 std cap chair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
K0824	PWC gp 2 hd seat/back	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
K0825	PWC gp 2 hd cap chair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
K0826	PWC gp 2 vhd seat/back	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
K0827	PWC gp vhd cap chair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
K0828	PWC gp 2 xtra hd seat/back	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
K0829	PWC gp 2 xtra hd cap chair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—

K0830	PWC gp2 std seat elevate s/b	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
K0831	PWC gp2 std seat elevate cap	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
K0835	PWC gp2 std sing pow opt s/b	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
K0836	PWC gp2 std sing pow opt cap	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
K0837	PWC gp 2 hd sing pow opt s/b	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
K0838	PWC gp 2 hd sing pow opt cap	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
K0839	PWC gp2 vhd sing pow opt s/b	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
K0840	PWC gp2 xhd sing pow opt s/b	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
K0841	PWC gp2 std mult pow opt s/b	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
K0842	PWC gp2 std mult pow opt cap	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
K0843	PWC gp2 hd mult pow opt s/b	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
K0848	PWC gp 3 std seat/back	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
K0849	PWC gp 3 std cap chair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—

K0850	PWC gp 3 hd seat/back	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
K0851	PWC gp 3 hd cap chair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
K0852	PWC gp 3 vhd seat/back	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
K0853	PWC gp 3 vhd cap chair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
K0854	PWC gp 3 xhd seat/back	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
K0855	PWC gp 3 xhd cap chair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
K0856	PWC gp3 std sing pow opt s/b	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
K0857	PWC gp3 std sing pow opt cap	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
K0858	PWC gp3 hd sing pow opt s/b	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
K0859	PWC gp3 hd sing pow opt cap	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
K0860	PWC gp3 vhd sing pow opt s/b	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
K0861	PWC gp3 std mult pow opt s/b	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
K0862	PWC gp3 hd mult pow opt s/b	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—

K0863	PWC gp3 vhd mult pow opt s/b	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
K0864	PWC gp3 xhd mult pow opt s/b	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
K0868	PWC gp 4 std seat/back	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
K0869	PWC gp 4 std cap chair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
K0870	PWC gp 4 hd seat/back	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
K0871	PWC gp 4 vhd seat/back	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
K0877	PWC gp4 std sing pow opt s/b	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
K0878	PWC gp4 std sing pow opt cap	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
K0879	PWC gp4 hd sing pow opt s/b	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
K0880	PWC gp4 vhd sing pow opt s/b	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
K0884	PWC gp4 std mult pow opt s/b	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–

K0885	PWC gp4 std mult pow opt cap	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
K0886	PWC gp4 hd mult pow s/b	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
K0890	PWC gp5 ped sing pow opt s/b	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
K0891	PWC gp5 ped mult pow opt s/b	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
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 to avoid post-service review.	–	–	–
K1004	Lo freq us diathermy device	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
K1009	Speech volume modulation sys	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	12/31/2023	Retire effective 12/31/2023
K1018	Ext up limb tremor stim wris	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	12/31/2023	Retire effective 12/31/2023
K1019	Supp ext up limb tremor stim	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	12/31/2023	Retire effective 12/31/2023
K1020	Non-invasive vagus nerv stim	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	12/31/2023	Retire effective 12/31/2023
K1022	Endoskel posit rotat unit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
K1024	Non pneum comp control cal	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Add effective 07/01/2023	12/31/2023	Retire effective 12/31/2023

K1025	Non pneum compress full arm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Add effective 07/01/2023	12/31/2023	Retire effective 12/31/2023
K1027	Oral dev without fix mech	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, and may require Prior Authorization per contract agreement.	–	–	–
K1030	Ext recharge bat replacement	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
K1031	Non pneu comp control w/o ca	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Add effective 07/01/2023	12/31/2023	Retire effective 12/31/2023
K1032	Non pneum seq comp full leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Add effective 07/01/2023	12/31/2023	Retire effective 12/31/2023
K1033	Non pneum seq comp half leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Add effective 07/01/2023	12/31/2023	Retire effective 12/31/2023
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 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 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 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 to avoid post-service review.	–	–	–
L2999	Lower extremity orthosis NOS	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
L3040	Ft arch suprt premold longit	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

L3050	Foot arch supp premold metat	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
L3060	Foot arch supp longitud/meta	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
L3649	Orthopedic shoe modifica NOS	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
L3999	Upper limb orthosis NOS	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
L5610	Above knee hydracadence	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review 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 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 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 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 to avoid post-service review.	–	–	–
L5620	Test socket below knee	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
L5624	Test socket above knee	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
L5629	Below knee acrylic socket	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review 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 to avoid post-service review.	–	–	–
L5638	Below knee leather socket	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–

L5639	Below knee wood socket	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
L5640	Knee disarticulat leather so	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
L5642	Above knee leather socket	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
L5644	Above knee wood socket	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review 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 to avoid post-service review.	–	–	–
L5646	Below knee cushion socket	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
L5647	Below knee suction socket	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
L5648	Above knee cushion socket	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review 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 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 to avoid post-service review.	–	–	–
L5670	Bk molded supracondylar susp	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
L5676	Bk knee joints single axis p	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
L5704	Custom shape cover BK	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–

L5705	Custom shape cover AK	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review 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 to avoid post-service review.	—	—	—
L5710	Knee-shin exo sng axi mnl loc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
L5711	Knee-shin exo mnl lock ultra	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
L5712	Knee-shin exo frict swg & st	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review 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 to avoid post-service review.	—	—	—
L5716	Knee-shin exo mech stance ph	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
L5718	Knee-shin exo frct swg & sta	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review 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 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 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 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 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 to avoid post-service review.	—	—	—

L5785	Exoskeletal bk ultralt mater	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review 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 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 to avoid post-service review.	—	—	—
L5810	Endoskel knee-shin mnl lock	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
L5811	Endo knee-shin mnl lck ultra	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
L5812	Endo knee-shin frct swg & st	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
L5814	Endo knee-shin hydal swg ph	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review 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 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 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 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 to avoid post-service review.	—	—	—
L5826	Miniature knee joint	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review 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 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 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 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 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 to avoid post-service review.	–	–	–
L5858	Stance phase only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review 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 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 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 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 to avoid post-service review.	–	–	–
L5966	Hip flexible cover system	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
L5968	Multiaxial ankle w dorsiflex	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review 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 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 to avoid post-service review.	–	–	–

L5972	Flexible keel foot	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
L5973	Ank-foot sys dors-plant flex	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
L5974	Foot single axis ankle/foot	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
L5976	Energy storing foot	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
L5978	Ft prosth multiaxial anl/ft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review 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 to avoid post-service review.	—	—	—
L5980	Flex foot system	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review 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 to avoid post-service review.	—	—	—
L5982	Exoskeletal axial rotation u	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
L5984	Endoskeletal axial rotation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review 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 to avoid post-service review.	—	—	—
L5986	Multi-axial rotation unit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review 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 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 to avoid post-service review.	–	–	–
L6611	Additional switch ext power	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
L6621	Flex/ext wrist w/wo friction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
L6880	ELECTRIC HAND SWITCH OR MYOELECTRIC CONTROLLED INDEPENDENTLY ARTICULATING DIGITS ANY GRASP PATTERN OR COMBINATION OF GRASP PATTERNS INCLUDES MOTOR(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
L6882	Microprocessor control uplmb	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
L6920	Wrist disarticul switch ctrl	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
L6925	Wrist disart myoelectronic c	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
L6930	Below elbow switch control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
L6935	Below elbow myoelectronic ct	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
L6940	Elbow disarticulation switch	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
L6945	Elbow disart myoelectronic c	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–

L6950	Above elbow switch control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
L6955	Above elbow myoelectronic ct	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
L6960	Shldr disartic switch contro	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
L6965	Shldr disartic myoelectronic	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
L6970	Interscapular-thor switch ct	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
L6975	Interscap-thor myoelectronic	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
L7007	Adult electric hand	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
L7008	Pediatric electric hand	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
L7009	Adult electric hook	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
L7040	Prehensile actuator	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
L7045	Pediatric electric hook	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
L7170	Electronic elbow hosmer swit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
L7180	Electronic elbow sequential	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–

L7181	Electronic elbo simultaneous	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
L7185	Electron elbow adolescent sw	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
L7186	Electron elbow child switch	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
L7190	Elbow adolescent myoelectron	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
L7191	Elbow child myoelectronic ct	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
L7259	Electronic wrist rotator any	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review 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 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 to avoid post-service review.	—	—	—
L7364	Twelve volt battery utah/equ	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
L7366	Battery chrgr 12 volt utah/e	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
L7367	Replacemnt lithium ionbatter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
L7368	Lithium ion battery charger	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	—	—	—
L7499	Upper extremity prosthes NOS	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	—	—	—

L8039	Breast prosthesis NOS	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
L8048	Unspec maxillofacial prosth	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
L8499	Unlisted misc prosthetic ser	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
L8600	Implant breast silicone/eq	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, and may require Prior Authorization per contract agreement.	–	–	–
L8603	Collagen imp urinary 2.5 ml	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	2/14/2024	Retire effective 02/14/2024
L8604	Dextranomer/hyaluronic acid	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
L8605	Inj bulking agent anal canal	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
L8606	Synthetic implnt urinary 1ml	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
L8607	Inj vocal cord bulking agent	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
L8609	Artificial cornea	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
L8612	Aqueous shunt prosthesis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
L8679	Imp neurosti pls gn any type	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
L8680	Implt neurostim elctr each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–

L8682	Implt neurostim radiofreq rec	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
L8685	Implt nrostm pls gen sng rec	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
L8686	Implt nrostm pls gen sng non	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
L8687	Implt nrostm pls gen dua rec	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
L8688	Implt nrostm pls gen dua non	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
L8694	Aoi transducer/actuator repl	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
L8695	External recharge sys extern	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review 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 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 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 to avoid post-service review.	–	–	–
M0075	Cellular therapy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
M0076	Prolotherapy	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
M0100	Intragastric hypothermia	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

M0240	Casiri and imdev repeat	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	6/1/2023	–	–
M0241	Casiri and imdev repeat hm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	6/1/2023	–	–
M0243	Casirivi and imdevi inj	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	6/1/2023	–	–
M0244	Casirivi and imdevi inj hm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	6/1/2023	–	–
M0245	bamlan and etesev infusion	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	6/1/2023	–	–
M0246	Bamlan and etesev infus home	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	6/1/2023	–	–
M0300	IV chelationtherapy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review 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.	–	–	–
P2029	Congo red blood test	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 to avoid post-service review.	–	–	–
P9020	Plaelet rich plasma unit	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
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.	–	–	–
Q0035	Cardiokymography	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

Q0240	Casirivi and imdevi 600mg	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	6/1/2023	—	—
Q0243	casirivimab and imdevimab	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	6/1/2023	—	—
Q0244	Casirivi and imdevi 1200 mg	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	6/1/2023	—	—
Q0245	bamlanivimab and etesevima	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	6/1/2023	—	—
Q0482	Microprcsr cu combo vad rep	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review 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 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 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 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 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 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 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 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	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
Q0509	Mis sup/ac imp VAD nopay med	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
Q0510	Dispens fee immunosuppressive	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
Q0511	Sup fee antiem antica immuno	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
Q0512	Px sup fee anti-can sub pres	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
Q2026	Radiesse injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
Q2028	Inj sculptra 0.5mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
Q2039	Influenza virus vaccine nos	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
Q2041	Axicabtagene ciloleucel car+	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, and may require Prior Authorization per contract agreement.	–	–	–
Q2042	Tisagenlecleucel car-pos t	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, and may require Prior Authorization 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, and may require Prior Authorization per contract agreement.	–	–	–
Q2054	Lisocabtagene mara car pos t	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, and may require Prior Authorization per contract agreement.	–	–	–

Q2055	Idecabtagene vicleucel car	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, and may require Prior Authorization per contract agreement.	–	–	–
Q2056	Ciltacabtagene car-pos t	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, and may require Prior Authorization per contract agreement.	–	–	–
Q4050	Cast supplies unlisted	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
Q4051	Splint supplies misc	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
Q4082	Drug/bio NOC part B drug CAP	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
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 to avoid post-service review.; Procedures/services not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
Q4100	Skin substitute NOS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.; Procedures/services 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 to avoid post-service review.	–	–	–
Q4102	Oasis wound matrix	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
Q4103	Oasis burn matrix	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4104	Integra BMWD	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–

Q4105	Integra drt or omnigraft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
Q4106	Dermagraft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
Q4107	Graftjacket	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
Q4108	Integra matrix	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
Q4110	Primatrix	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4111	Gammagraft	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4112	Cymetra injectable	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4113	Graftjacket xpress	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4114	Integra flowable wound matri	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
Q4115	Alloskin	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4116	Alloderm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
Q4117	Hyalomatrix	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4118	Matristem micromatrix	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–

Q4121	Theraskin	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4122	Dermacell awm porous sq cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
Q4123	ALLOSKIN RT PER SQUARE CENTIMETER	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4124	OASIS ULTRA TRI-LAYER WOUND MATRIX PER SQUARE CENTIMETER	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4125	ARTHROFLEX PER SQUARE CENTIMETER	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4126	Memoderm/derma/tranz/integup	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4127	TALYMED PER SQUARE CENTIMETER	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4128	Flexhd/allopatchhd/sq cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
Q4130	STRATTICE TM PER SQUARE CENTIMETER	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4132	Grafix core grafixpl core	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review 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 to avoid post-service review.	–	–	–
Q4134	hMatrix	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4135	Mediskin	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–

Q4136	EZderm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4137	Amnioexcel biodexcel 1sq cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4138	Biodfence dryflex 1cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4139	Amnio or biodmatrix inj 1cc	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4140	Biodfence 1cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4141	Alloskin ac 1 cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4142	Xcm biologic tiss matrix 1cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4143	Repriza 1cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4145	Epifix inj 1mg	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4146	Tensix 1cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4147	Architect ecm px fx 1 sq cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4148	Neox neox rt or clarix cord	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4149	Excellagen 0.1 cc	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–

Q4150	Allowrap ds or dry 1 sq cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4151	Amnioband guardian 1 sq cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
Q4152	Dermapure 1 square cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4153	Dermavest plurivest sq cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4154	Biovance 1 square cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
Q4155	Neoxflo or clarixflo 1 mg	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4156	Neox 100 or clarix 100	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4157	Revitalon 1 square cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4158	Kerecis omega3 per sq cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4159	Affinity1 square cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
Q4160	Nushield 1 square cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4161	Bio-connekt per square cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4162	Wndex flw bioskn flw 0.5cc	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–

Q4163	Woundex bioskin per sq cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4164	Helicoll per square cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4165	Keramatrix Kerasorb sq cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4166	Cytal per square centimeter	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4167	Truskin per sq centimeter	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4168	Amnioband 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
Q4169	Artacent wound per sq cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4170	Cygnus per sq cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4171	Interfyl 1 mg	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4173	Palingen or palingen xplus	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4174	Palingen or promatrx	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4175	Miroderm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4176	Neopatch or therion per square centimeter	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–

Q4177	Floweramnioflo 0.1 cc	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4178	Floweramniopatch per sq cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4179	Flowerderm per sq cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4180	Revita per sq cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4181	Amnio wound per square cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4182	Transcyte per sq centimeter	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4183	Surgigraft 1 sq cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4184	Cellesta or duo per sq cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4185	Cellesta flowab amnion 0.5cc	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4186	Epifix 1 sq cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
Q4187	Epicord 1 sq cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
Q4188	Amnioarmor 1 sq cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4189	Artacent ac 1 mg	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–

Q4190	Artacent ac 1 sq cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4191	Restorigin 1 sq cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4192	Restorigin 1 cc	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4193	Coll-e-derm 1 sq cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4194	Novachor 1 sq cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4195	Puraply 1 sq cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4196	Puraply am 1 sq cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4197	Puraply xt 1 sq cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4198	Genesis amnio membrane 1sqcm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4199	Cygnus matrix per sq cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4200	Skin te 1 sq cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4201	Matrion 1 sq cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4202	Keroxx (2.5g/cc) 1cc	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–

Q4203	Derma-gide 1 sq cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4204	Xwrap 1 sq cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4205	Membrane graft or wrap sq cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4206	Fluid flow or fluid gf 1 cc	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4208	Novafix per sq cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4209	Surgraft per sq cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4210	Axotl graf dualgraf sq cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4211	Amnion bio or axobio sq cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4212	Allogen per cc	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4213	Ascent 0.5 mg	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4214	Cellesta cord per sq cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4215	Axotl ambient cryo 0.1 mg	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4216	Artacent cord per sq cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–

Q4217	Woundfix biowound plus xplus	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4218	Surgicord per sq cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4219	Surgigraft dual per sq cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4220	Bellacell HD Surederm sq cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4221	Amniowrap2 per sq cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4222	Progenamatrix per sq cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4224	Hhf10-p per sq cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4225	Amniobind per sq cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4227	Amniocore per sq cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4229	Cogenex amnio memb per sq cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4230	Cogenex flow amnion 0.5 cc	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4231	Corplex p per cc	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4232	Corplex per sq cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–

Q4233	Surfactor /nudyn per 0.5 cc	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4234	Xcellerate per sq cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4235	Amniorepair or altiply sq cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4236	Carepatch per sq cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4237	Cryo-cord per sq cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4238	Derm-maxx per sq cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4239	Amnio-maxx or lite per sq cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4240	Corecyte topical only 0.5 cc	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4241	Polycyte topical only 0.5cc	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4242	Amniocyte plus per 0.5 cc	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4244	Procenta per 200 mg	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4245	Amniotext per cc	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4246	Coretext or protext per cc	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–

Q4247	Amniotext patch per sq cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4248	Dermacyte amn mem allo sq cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4249	Amniply per sq cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4250	Amnioamp-mp per sq cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4251	Vim per square centimeter	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4252	Vendaje per square centimet	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4253	Zenith amniotic membrane psc	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4254	Novafix dl per sq cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4255	Reguard topical use per sq	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4256	Mlg complet per sq cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4257	Relese per sq cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4258	Enverse per sq cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4259	Celera per sq cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–

Q4260	Signature apatch per sq cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4261	Tag per square centimeter	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
Q4262	Dual layer impax per sq cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	1/1/2023	–	–
Q4263	Surgraft tl per sq cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	1/1/2023	–	–
Q4264	Cocoon membrane per sq cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	1/1/2023	–	–
Q4265	Neostim TI Per Sq Cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	9/1/2023	–	–
Q4266	Neostim Per Sq Cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	9/1/2023	–	–
Q4267	Neostim DI Per Sq Cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	9/1/2023	–	–
Q4268	Surgraft Ft Per Sq Cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	9/1/2023	–	–
Q4269	Surgraft Xt Per Sq Cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	9/1/2023	–	–
Q4270	Complete SI Per Sq Cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	9/1/2023	–	–
Q4271	Complete Ft Per Sq Cm	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	9/1/2023	–	–
Q5009	Hospice care NOS	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–

Q5106	Inj retacrit non-esrd use	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, and may require Prior Authorization per contract agreement.	–	–	–
Q5109	Injection ixifi 10 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, and may require Prior Authorization per contract agreement.	–	–	–
Q5124	Inj. byooviz 0.1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
Q5128	Inj, Cimerli, 0.1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2023	–	–
S0013	Esketamine nasal spray	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
S0117	Tretinoin topical 5 g	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
S0142	Colistimethate inh sol mg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
S0155	Epoprostenol dilutant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
S0157	Becaplermin gel 1% 0.5 gm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, and may require Prior Authorization per contract agreement.	–	–	–
S0189	Testosterone pellet 75 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, and may require Prior Authorization 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	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-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 to avoid post-service review.	–	–	–
S0320	RN telephone calls to DMP	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

S0590	Misc integral lens serv	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
S0596	Phakic iol refractive error	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review 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.	–	–	–
S1001	Deluxe item	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
S1002	Custom item	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
S2080	Laup	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
S2103	Adrenal tissue transplant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
S2112	Knee arthroscop harv	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
S2117	Arthroereisis subtalar	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
S2118	Total hip resurfacing	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
S2140	Cord blood harvesting	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
S2142	Cord blood-derived stem-cell	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
S2150	BMT harv/transpl 28d pkg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–

S2202	Echosclerotherapy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
S2230	Implant semi-imp hear	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
S2300	Arthroscopy shoulder surgi	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
S2403	Fetal surg pulmon sequest	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
S2405	Fetal surg sacrococ teratoma	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review 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 to avoid post-service review.	–	–	–
S3600	Stat lab	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
S3601	Stat lab home/nf	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
S3650	Saliva test hormone level;	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
S3652	Saliva test hormone level;	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
S4015	Complete IVF nos case rate	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical 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.	–	–	–
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.	–	–	–
S4040	Monit store cryo embryo 30 d	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.	–	–	–
S4995	Smoking cessation gum	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
S5100	Adult daycare services 15min	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
S5101	Adult day care per half day	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
S5102	Adult day care per diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
S5105	Centerbased day care per diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
S5108	Homecare train pt 15 min	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
S5109	Homecare train pt session	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
S5110	Family homecare training 15m	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
S5111	Family homecare train/sessio	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
S5115	Nonfamily homecare train/15m	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
S5116	Nonfamily HC train/session	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
S5120	Chore services per 15 min	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
S5121	Chore services per diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
S5125	Attendant care service /15m	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
S5126	Attendant care service /diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
S5130	Homaker service nos per 15m	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

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

S5181	HH respiratory thrpy nos/day	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
S5185	Med reminder serv per month	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
S5199	Personal care item nos each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
S5199	Personal care item nos each	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 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	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
S8415	Supplies for home delivery	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
S8460	Camisole post-mast	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
S8930	Auricular electrostimulation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
S8948	Low-level laser trmt 15 min	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
S9001	Home uterine monitor with or	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
S9055	Procuren or other growth fac	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–

S9056	Coma stimulation per diem	EIU: Procedures/services reviewed against Medical Policy Criteria and deemed Experimental/Investigational/Unproven.	–	–	–
S9090	Vertebral axial decompressio	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
S9117	Back school visit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
S9122	Home health aide or certifie	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
S9125	Respite care in the home p	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
S9379	HIT noc per diem	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
S9436	Lamaze class	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
S9437	Childbirth refresher class	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
S9438	Cesarean birth class	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
S9439	VBAC class	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
S9444	Parenting class	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
S9445	PT education noc individ	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
S9446	PT education noc group	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
S9447	Infant safety class	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
S9449	Weight mgmt class	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
S9451	Exercise class	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
S9454	Stress mgmt class	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
S9482	Family stabilization 15 min	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

S9542	HT inj noc per diem	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
S9558	HT inj growth horm diem	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
S9560	HT inj hormone diem	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
S9810	HT pharm per hour	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
S9900	Christian Sci Pract visit	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
S9960	Air ambulanc nonemerg fixed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
S9961	Air ambulan nonemerg rotary	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
S9970	Health club membership yr	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.	–	–	–
S9976	Lodging per diem	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.	–	–	–
S9977	Meals per diem	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–

S9981	Med record copy admin	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
S9982	Med record copy per page	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
S9986	Not medically necessary svc	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
S9988	Serv part of phase I trial	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
S9989	Services outside US	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
S9990	Services provided as part of	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
S9991	Services provided as part of	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
S9992	Transportation costs to and	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
S9994	Lodging costs (e.g. hotel ch	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
S9996	Meals for clinical trial par	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
S9999	Sales tax	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
T1505	Elec med comp dev noc	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–

T1999	NOC retail items and supplies	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
T2012	Habil ed waiver per diem	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
T2013	Habil ed waiver per hour	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
T2014	Habil prevoc waiver per d	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
T2015	Habil prevoc waiver per hr	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
T2016	Habil res waiver per diem	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
T2017	Habil res waiver 15 min	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
T2018	Habil sup empl waiver/diem	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
T2019	Habil sup empl waiver 15min	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
T2020	Day habil waiver per diem	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
T2021	Day habil waiver per 15 min	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
T2024	Serv asmnt/care plan waiver	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–

T2025	Waiver service nos	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
T2026	Special childcare waiver/d	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
T2027	Spec childcare waiver 15 min	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
T2028	Special supply nos waiver	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
T2029	Special med equip noswaiver	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
T2030	Assist living waiver/month	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
T2031	Assist living waiver/diem	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
T2032	Res care nos waiver/month	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
T2033	Res nos waiver per diem	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
T2034	Crisis interven waiver/diem	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
T2035	Utility services waiver	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
T2036	Camp overnite waiver/session	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
T2037	Camp day waiver/session	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–

T2038	Comm trans waiver/service	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
T2039	Vehicle mod waiver/service	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
T2040	Financial mgt waiver/15min	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
T2041	Support broker waiver/15 min	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
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.	–	–	–
V2219	Lens bifocal seg width over	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-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.	–	–	–
V2610	Single lens spectacle mount	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
V2615	Telescop/othr compound lens	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 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.	–	–	–
V2715	Prism lens/es	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

V2718	Fresnell prism press-on lens	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
V2730	Special base curve	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.	–	–	–
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.	–	–	–
V2760	Scratch resistant coating	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
V2770	Occluder lens/es	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 to avoid post-service review.	–	–	–
V2788	Presbyopia-correct function	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
V2799	Misc vision item or service	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
V2799	Misc vision item or service	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
V5090	Hearing aid dispensing fee	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
V5095	Implant mid ear hearing pros	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
V5267	Hearing aid sup/access/dev	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
V5274	ALD unspecified	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
V5287	Ald fm/dm receiver NOS	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–

V5298	Hearing aid noc	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
V5299	Hearing service	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
V5364	Dysphagia screening	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
C1820	Generator neuro rechg bat sy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2023	12/31/2999	–
J1726	Makena 10 mg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	7/15/2023	12/31/2999	–
J1729	Inj hydroxyprogst capoat nos	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	7/15/2023	12/31/2999	–
L8678	Ext sply implt neurostim	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2023	12/31/2999	–
L8681	Pt prgrm for implt neurostim	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2023	12/31/2999	–
L8683	Radiofq trsmtr for implt neu	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2023	12/31/2999	–
L8689	External recharg sys intern	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2023	12/31/2999	–
Q4284	Dermabind sl per sq cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/15/2023	11/30/2023	–
Q4284	Dermabind sl per sq cm	EIU: Procedures/services not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2023	12/31/2999	Add effective 12/01/2023
Q4283	Biovance tri or 3l sq cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/15/2023	12/31/2999	–
Q4282	Cygnus dual per sq cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/15/2023	11/30/2023	–

Q4282	Cygnus dual per sq cm	EIU: Procedures/services not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2023	12/31/2999	Add effective 12/01/2023
Q4281	Barrera slor dl per sq cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/15/2023	11/30/2023	–
Q4281	Barrera slor dl per sq cm	EIU: Procedures/services not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2023	12/31/2999	Add effective 12/01/2023
Q4280	Xcell amnio matrix per sq cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/15/2023	11/30/2023	–
Q4280	Xcell amnio matrix per sq cm	EIU: Procedures/services not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2023	12/31/2999	Add effective 12/01/2023
Q4278	Epieffect per sq cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/15/2023	11/30/2023	–
Q4278	Epieffect per sq cm	EIU: Procedures/services not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2023	12/31/2999	Add effective 12/01/2023
Q4277	Woundplus e-grat per sq cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/15/2023	11/30/2023	–
Q4277	Woundplus e-grat per sq cm	EIU: Procedures/services not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2023	12/31/2999	Add effective 12/01/2023
Q4276	Orion per sq cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/15/2023	11/30/2023	–
Q4276	Orion per sq cm	EIU: Procedures/services not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2023	12/31/2999	Add effective 12/01/2023

Q4275	Esano aca per sq cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/15/2023	11/30/2023	–
Q4275	Esano aca per sq cm	EIU: Procedures/services not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2023	12/31/2999	Add effective 12/01/2023
Q4274	Esano ac per sq cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/15/2023	11/30/2023	–
Q4274	Esano ac per sq cm	EIU: Procedures/services not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2023	12/31/2999	Add effective 12/01/2023
Q4273	Esano aaa per sq cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/15/2023	11/30/2023	–
Q4273	Esano aaa per sq cm	EIU: Procedures/services not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2023	12/31/2999	Add effective 12/01/2023
Q4272	Esano a per sq cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/15/2023	11/30/2023	–
Q4272	Esano a per sq cm	EIU: Procedures/services not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2023	12/31/2999	Add effective 12/01/2023
J2778	Ranibizumab injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/15/2023	12/31/2999	–
J0179	Inj brolucizumab-dbl 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/15/2023	12/31/2999	–
J0178	Aflibercept injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/15/2023	12/31/2999	–
C9785	Endo outlet restrict w/tube	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/15/2023	11/30/2023	–

C9785	Endo outlet restrict w/tube	EIU: Procedures/services not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2023	12/31/2999	Add effective 12/01/2023
C9784	Endo sleeve gastro w/tube	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/15/2023	11/30/2023	—
C9784	Endo sleeve gastro w/tube	EIU: Procedures/services not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2023	12/31/2999	Add effective 12/01/2023
67028	INJECTION EYE DRUG	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/15/2023	12/31/2999	—
0809T	ARTHRD SI JT PRQ TFX&IMPLT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/15/2023	11/30/2023	—
0809T	ARTHRD SI JT PRQ TFX&IMPLT	EIU: Procedures/services not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2023	12/31/2999	Add effective 12/01/2023 Retire effective 12/31/2023
0545T	TCAT TV ANNULUS RCNSTJ	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2023	12/31/2999	—
0569T	TTVR PERQ APPR 1ST PROSTH	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2023	12/31/2999	—
0570T	TTVR PERQ EA ADDL PROSTH	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2023	12/31/2999	—
0600T	IRE ABLTJ 1+TUM ORGAN PERQ	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2023	12/31/2999	—
0601T	IRE ABLTJ 1+TUMORS OPEN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2023	12/31/2999	—
0740T	REM AUTON ALG NSLN CAL SETUP	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2023	12/31/2999	—

0741T	REM AUTON ALG NSLN DATA COLL	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2023	12/31/2999	_
A4341	Iduc valve pat inst repl	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2023	12/31/2999	_
A4342	Iduc valve sply repl	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2023	12/31/2999	_
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 to avoid post-service review.	3/1/2024	12/31/2999	Add effective 03/01/2024
98978	REM THER MNTR DEV SPLY CBT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2023	12/31/2999	_
J3111	Inj. romosozumab-aqqg 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2024	12/31/2999	Add effective 03/01/2024
J2796	Romiplostim injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2024	12/31/2999	Add effective 03/01/2024
J2354	Octreotide inj non-depot	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2024	12/31/2999	Add effective 03/01/2024
J2353	Octreotide injection depot	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2024	12/31/2999	Add effective 03/01/2024
J1930	Lanreotide injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2024	12/31/2999	Add effective 03/01/2024
J0485	Belatacept injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2024	12/31/2999	Add effective 03/01/2024
0597T	TEMP FML IU VALVE-PMP RPLCMT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2023	12/31/2999	_
0596T	TEMP FML IU VLV-PMP 1ST INSJ	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2023	12/31/2999	_

59072	UMBILICAL CORD OCCLUD W/US	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2023	12/31/2999	—
59076	FETAL SHUNT PLACEMENT W/US	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2023	12/31/2999	—
S2400	Fetal surg congen hernia	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2023	12/31/2999	—
S2401	Fetal surg urin trac obstr	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2023	12/31/2999	—
S2402	Fetal surg cong cyst malf	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2023	12/31/2999	—
S2404	Fetal surg myelomeningo	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2023	12/31/2999	—
S2409	Fetal surg noc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2023	12/31/2999	—
L5991	Add to lower ext prostheses, osseointegrated ext prost connector	EIU: Procedures/services not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	10/1/2023	12/31/2999	—
E0490	Power source/control electronics unit for oral device/appliance for neuro musc elec stim tongue muscle	EIU: Procedures/services not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	10/1/2023	12/31/2999	—
E0491	Oral device/appliance for neuro musc elec stim tongue muscle, 90-day supply	EIU: Procedures/services not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	10/1/2023	12/31/2999	—
K1036	Supplies/accessories low freq ultrasonic diathermy per month	EIU: Procedures/services not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	10/1/2023	12/31/2999	—
Q4285	Nudyn dl or nudyn dl mesh, per sq cm	EIU: Procedures/services not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	10/1/2023	12/31/2999	—

Q4286	Nudyn sl or nudyn slw, per sq cm	EIU: Procedures/services not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	10/1/2023	12/31/2999	–
A2022	Innovaburn or innovamatrix xl, per sq cm	EIU: Procedures/services not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	10/1/2023	12/31/2999	–
A2023	Innovamatrix pd, 1 mg	EIU: Procedures/services not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	10/1/2023	12/31/2999	–
A2024	Resolve matrix, per sq cm	EIU: Procedures/services not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	10/1/2023	12/31/2999	–
A2025	Miro3d, per cubic cm	EIU: Procedures/services not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	10/1/2023	12/31/2999	–
A4560	Nmes disposable	EIU: Procedures/services not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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 to avoid post-service review.	10/1/2023	12/31/2023	Retire effective 12/31/2023
A4560	Nmes disposable	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/15/2023	1/14/2024	Add effective 10/15/2023 Retire effective 01/14/2024
J0174	Inj lecanemab-irmb 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2023	12/31/2999	–
K1017	Monthly supp use with k1016	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/15/2023	12/31/2023	Retire effective 12/31/2023
K1016	Trans elec nerv for trigemin	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/15/2023	12/31/2023	Retire effective 12/31/2023

J0741	Inj cabote rilpivir 2mg 3mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/15/2023	12/31/2999	–
J0739	Injection cabotegravir 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/15/2023	12/31/2999	–
0322U	NEURO ASD MEAS 14 ACYL CARN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/15/2023	2/1/2024	Add effective 10/1/2023 Retire effective 2/1/2024
0322U	NEURO ASD MEAS 14 ACYL CARN	EIU: Procedures/services not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	2/1/2024	12/31/2999	Add effective 2/1/2024
S2102	Islet cell tissue transplant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2023	12/31/2999	–
95957	EEG DIGITAL ANALYSIS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2023	12/31/2999	–
95954	EEG MONITORING/GIVING DRUGS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2023	12/31/2999	–
95726	EEG PHY/QHP>84 HR W/VEEG	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2023	12/31/2999	–
95725	EEG PHY/QHP>84 HR W/O VID	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2023	12/31/2999	–
95724	EEG PHY/QHP>60<84 HR W/VEEG	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2023	12/31/2999	–
95723	EEG PHY/QHP>60<84 HR W/O VID	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2023	12/31/2999	–
95722	EEG PHY/QHP>36<60 HR W/VEEG	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2023	12/31/2999	–
95721	EEG PHY/QHP>36<60 HR W/O VID	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2023	12/31/2999	–

95720	EEG PHY/QHP EA INCR W/VEEG	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2023	12/31/2999	—
95719	EEG PHYS/QHP EA INCR W/O VID	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2023	12/31/2999	—
95718	EEG PHYS/QHP 2-12 HR W/VEEG	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2023	12/31/2999	—
95717	EEG PHYS/QHP 2-12 HR W/O VID	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2023	12/31/2999	—
95716	VEEG EA 12-26HR CONT MNTR	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2023	12/31/2999	—
95715	VEEG EA 12-26HR INTMT MNTR	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2023	12/31/2999	—
95714	VEEG EA 12-26 HR UNMNTR	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2023	12/31/2999	—
95713	VEEG 2-12 HR CONT MNTR	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2023	12/31/2999	—
95712	VEEG 2-12 HR INTMT MNTR	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2023	12/31/2999	—
95711	VEEG 2-12 HR UNMONITORED	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2023	12/31/2999	—
95710	EEG W/O VID EA 12-26HR CONT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2023	12/31/2999	—
95709	EEG W/O VID EA 12-26HR INTMT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2023	12/31/2999	—
95708	EEG WO VID EA 12-26HR UNMNTR	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2023	12/31/2999	—

95707	EEG W/O VID 2-12HR CONT MNTR	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2023	12/31/2999	–
95706	EEG WO VID 2-12HR INTMT MNTR	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2023	12/31/2999	–
95705	EEG W/O VID 2-12 HR UNMNTR	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2023	12/31/2999	–
95700	EEG CONT REC W/VID EEG TECH	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2023	12/31/2999	–
91117	COLON MOTILITY 6 HR STUDY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2023	12/31/2999	–
0072T	US LEIOMYOMATA ABLATE >200	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/1/2023	12/31/2999	Add effective 12/1/2023
0071T	US LEIOMYOMATA ABLATE <200	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/1/2023	12/31/2999	Add effective 12/1/2023
64624	DSTRJ NULYT AGT GNCLR NRV	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/1/2023	12/31/2999	Add effective 12/1/2023
41872	REPAIR GUM	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2024	12/31/2999	Add effective 02/01/2024
Q2049	Imported Lipodox inj	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/1/2024	12/31/2999	Add effective 04/01/2024
0546T	RF SPECTRSC NTRAOP MRGN ASMT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2024	12/31/2999	Add effective 01/01/2024
0369U	IADNA GI PTHGN 31 ORG&21 ARG	EIU: Procedures/services not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999	Add effective 05/15/2024
C1832	Auto cell process sys	EIU: Procedures/services not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999	Add effective 05/15/2024

22836	ANT THRC VRT BODY TETHRG <7	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999	Add effective 05/15/2024
22837	ANT THRC VRT BODY TETHRG 8+	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999	Add effective 05/15/2024
22838	REV RPLC/RMV THRC VRT TETHRG	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999	Add effective 05/15/2024
27278	ARTHRD SI JT PRQ WO TFXJ 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).	5/15/2024	12/31/2999	Add effective 05/15/2024
31242	NSL/SINUS NDSC RF ABLTJ PNN	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999	Add effective 05/15/2024
31243	NSL/SINUS NDSC CRYOABLTJ PNN	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999	Add effective 05/15/2024
33276	INSJ PHRNC NRV STIM 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).	5/15/2024	12/31/2999	Add effective 05/15/2024
33277	INSJ PHRNC NRV STIM TRANSVNS	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999	Add effective 05/15/2024
33278	RMVL PHRNC NRV STIM 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).	5/15/2024	12/31/2999	Add effective 05/15/2024
33279	RMVL PHRNC NRV STIM TRANSVNS	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999	Add effective 05/15/2024

33280	RMVL PHRNC NRV STIM PG ONLY	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999	Add effective 05/15/2024
33281	REPOSG PHRNC NRV STIM TRNSVN	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999	Add effective 05/15/2024
33287	RMV&RPLCMT PHRNC NRV STIM PG	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999	Add effective 05/15/2024
33288	RMV&RPLCMT PHRNC NRV STIM 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).	5/15/2024	12/31/2999	Add effective 05/15/2024
52284	CYSTO RX BALO CATH URTL STRX	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999	Add effective 05/15/2024
53855	INSERT PROST URETHRAL STENT	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999	Add effective 05/15/2024
93150	THERAPY ACTIVATION IPNSS	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999	Add effective 05/15/2024
93151	INTERROG&PRGRMG IPNSS	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999	Add effective 05/15/2024
93152	INTERROG&PRGRMG IPNSS POLYSM	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999	Add effective 05/15/2024
93153	INTERROG W/O PRGRMG IPNSS	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999	Add effective 05/15/2024

0790T	REVJ RPLCMT/RMVL VRT TETHRG	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999	Add effective 05/15/2024
A4540	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).	5/15/2024	12/31/2999	Add effective 05/15/2024
A4542	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).	5/15/2024	12/31/2999	Add effective 05/15/2024
E0732	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).	5/15/2024	12/31/2999	Add effective 05/15/2024
E0734	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).	5/15/2024	12/31/2999	Add effective 05/15/2024
E3000	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).	5/15/2024	12/31/2999	Add effective 05/15/2024
Q0518	Supply fee hiv prep 90-days	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/2/2024	12/31/2999	Add effective 01/02/2024
Q0517	Supply fee hiv prep 60-days	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/2/2024	12/31/2999	Add effective 01/02/2024
Q0516	Supply fee hiv prep 30-days	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/2/2024	12/31/2999	Add effective 01/02/2024
J9334	Inj efgart-alfa 2mg hya-qvfc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	12/31/2999	Add effective 02/15/2024
J9333	Inj ronzanolixizum-noli 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	12/31/2999	Add effective 02/15/2024
J3401	Vyjuvek 5x10^9pfu/ml 0.1 ml	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	12/31/2999	Add effective 02/15/2024

J2508	Pegunigalsidase alfa-iwxj	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	12/31/2999	Add effective 02/15/2024
J1413	Inj delandistrogene mox rokl	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	12/31/2999	Add effective 02/15/2024
J1412	Inj roctavian ml 2x10^13vc g	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	12/31/2999	Add effective 02/15/2024
J1304	Inj tofersen intrathec 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	12/31/2999	Add effective 02/15/2024
E3000	Speech volume modulation sys	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	5/14/2024	Add effective 02/15/2024 Retire effective 05/14/2024
E0735	Non-invasive vagus nerv stim	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	12/31/2999	Add effective 02/15/2024
E0734	Ext up limb tremor stim wris	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	5/14/2024	Add effective 02/15/2024 Retire effective 05/14/2024
E0733	Trans elec nerv for trigemin	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	12/31/2999	Add effective 02/15/2024
E0732	Ces system	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	5/14/2024	Add effective 02/15/2024 Retire effective 05/14/2024
E0682	Non pneum compress full arm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	12/31/2999	Add effective 02/15/2024
E0681	Non pneu comp control w/o ca	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	12/31/2999	Add effective 02/15/2024
E0680	Non pneum comp control cal	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	12/31/2999	Add effective 02/15/2024
E0679	Non pneum seq comp half leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	12/31/2999	Add effective 02/15/2024

E0678	Non pneum seq comp full leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	12/31/2999	Add effective 02/15/2024
C9782	Blind myocar trpl bon marrow	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2024	12/31/2999	Add effective 02/15/2024
C9160	Inj daxibotulinumtoxina-lanm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2024	12/31/2999	Add effective 05/15/2024
C1832	Auto cell process sys	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2024	5/14/2024	Add effective 02/15/2024 Retire effective 05/14/2024
A9291	Pres dig cog behav thera fda	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2024	12/31/2999	Add effective 02/15/2024
A4542	Supp ext up limb tremor stim	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	5/14/2024	Add effective 02/15/2024 Retire effective 05/14/2024
A4541	Monthly supp use with e0733	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	12/31/2999	Add effective 02/15/2024
A4540	Trans elec nerv periph nerv	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	5/14/2024	Add effective 02/15/2024 Retire effective 05/14/2024
A4457	Enema tube any type repl	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999	Add effective 01/01/2024
97037	APPL MODALITY 1+LLLT PO PAIN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	12/31/2999	Add effective 02/15/2024
93153	INTERROG W/O PRGRMG IPNSS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	5/14/2024	Add effective 02/15/2024 Retire effective 05/14/2024
93152	INTERROG&PRGRMG IPNSS POLYSM	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	5/14/2024	Add effective 02/15/2024 Retire effective 05/14/2024
93151	INTERROG&PRGRMG IPNSS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	5/14/2024	Add effective 02/15/2024 Retire effective 05/14/2024
93150	THERAPY ACTIVATION IPNSS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	5/14/2024	Add effective 02/15/2024 Retire effective 05/14/2024

90683	RSV VACC MRNA LIPID NANO IM	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999	Add effective 01/01/2024
67516	SPRCHOROIDAL SPC NJX RX AGT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	12/31/2999	Add effective 02/15/2024
64597	INS/RPLCM PRQ ELTRD RA PN EA	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	12/31/2999	Add effective 02/15/2024
64596	INS/RPLCMT PRQ ELTRD RA PN 1	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	12/31/2999	Add effective 02/15/2024
61892	RMV SK-MNT CRNL NSTM PG/RCVR	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	12/31/2999	Add effective 02/15/2024
61891	REV/RPLCMT SK-MNT CRNL NSTM	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	12/31/2999	Add effective 02/15/2024
61889	INS SK-MNT CRNL NSTM PG/RCVR	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	12/31/2999	Add effective 02/15/2024
58580	TRANSCRV ABLTJ UTRN FIBRD RF	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	12/31/2999	Add effective 02/15/2024
52284	CYSTO RX BALO CATH URTL STRX	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	5/14/2024	Add effective 02/15/2024 Retire effective 05/14/2024
33288	RMV&RPLCMT PHRNC NRV STIM LD	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	5/14/2024	Add effective 02/15/2024 Retire effective 05/14/2024
33287	RMV&RPLCMT PHRNC NRV STIM PG	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	5/14/2024	Add effective 02/15/2024 Retire effective 05/14/2024
33281	REPOSG PHRNC NRV STIM TRNSVN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	5/14/2024	Add effective 02/15/2024 Retire effective 05/14/2024
33280	RMVL PHRNC NRV STIM PG ONLY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	5/14/2024	Add effective 02/15/2024 Retire effective 05/14/2024
33279	RMVL PHRNC NRV STIM TRANSVNS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	5/14/2024	Add effective 02/15/2024 Retire effective 05/14/2024

33278	RMVL PHRNC NRV STIM SYS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	5/14/2024	Add effective 02/15/2024 Retire effective 05/14/2024
33277	INSJ PHRNC NRV STIM TRANSVNS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	5/14/2024	Add effective 02/15/2024 Retire effective 05/14/2024
33276	INSJ PHRNC NRV STIM SYS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	5/14/2024	Add effective 02/15/2024 Retire effective 05/14/2024
31243	NSL/SINUS NDSC CRYOABLTJ PNN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	5/14/2024	Add effective 02/15/2024 Retire effective 05/14/2024
31242	NSL/SINUS NDSC RF ABLTJ PNN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	5/14/2024	Add effective 02/15/2024 Retire effective 05/14/2024
27278	ARTHRD SI JT PRQ WO TFXJ DEV	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	5/14/2024	Add effective 02/15/2024 Retire effective 05/14/2024
22838	REV RPLC/RMV THRC VRT TETHRG	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	5/14/2024	Add effective 02/15/2024 Retire effective 05/14/2024
22837	ANT THRC VRT BODY TETHRG 8+	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	5/14/2024	Add effective 02/15/2024 Retire effective 05/14/2024
22836	ANT THRC VRT BODY TETHRG <7	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	5/14/2024	Add effective 02/15/2024 Retire effective 05/14/2024
0812T	REM MLT DAY UROFLOW DEV SPLY	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999	Add effective 01/01/2024
0811T	REM MLT DAY UROFLOW SETUP	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999	Add effective 01/01/2024
0790T	REVJ RPLCMT/RMVL VRT TETHRG	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	5/14/2024	Add effective 02/15/2024 Retire effective 05/14/2024
0369U	IADNA GI PTHGN 31 ORG&21 ARG	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2024	5/14/2024	Add effective 02/15/2024 Retire effective 05/14/2024

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

This is not an exhaustive list of all codes. Codes may change, and this list may be updated throughout the year. The presence of codes on this list does not necessarily indicate coverage under the member benefits contract. Member contracts differ in their benefits. Always check eligibility and benefits first through the Availity® Essentials (availity.com) or your preferred web vendor portal to confirm coverage and other important details, including prior authorization or pre-notification requirements and vendors, if applicable. For some services/members, prior authorization may be required through Blue Cross and Blue Shield of Texas (BCBSTX). For other services/members, BCBSTX has contracted with Carelon Medical Benefits Management for utilization management and related services.

Services performed without prior authorization, if required, will be denied for payment and providers may not seek reimbursement from BCBSTX members. Obtaining prior authorization is not a substitute for checking eligibility and benefits.

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