

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

This list includes Current Procedural Terminology (CPT®) and/or Healthcare Common Procedure Coding System (HCPCS) codes related to services/categories for which prior authorization may be required as of January 1, 2024 unless otherwise indicated through Blue Cross and Blue Shield of New Mexico managed for one or more of our networks:

- PPOSM

-Blue Preferred EPO

-Blue Preferred Plus

-HMO

Utilization Management Process

This file is a searchable PDF.

Press "CTRL" and "F" keys at the same time to bring up the search box. Enter a procedure code or description of the service.

Procedure Code Groups	Procedure Code Group Description
Medical Policy Criteria (MP Criteria)	Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review
	(Predetermination) to avoid post-service review.
	Highlighted procedure/service in this code group may require Prior Authorization per contract agreement.
Non Covered	Procedures/services not covered by the Plan. Not subject to pre-service review.
	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
	Anesthesia For Manipulation Of The Spine Or For Closed	MP Criteria: Procedure/service reviewed against Medical			
00640	Procedures On The Cervical Thoracic Or Lumbar Spine	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Anesthesia For Intraperitoneal Procedures In Upper	MP Criteria: Procedure/service reviewed against Medical			
00797	Abdomen Including Laparoscopy; Gastric Restrictive	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Procedure For Morbid Obesity	avoid post-service review.			
07957	Weight Loss	Non Covered: Procedure/service not covered by the Plan.			
07937		Not subject to pre-service review.	_	-	_
11200	Removal Of Skin Tags Multiple Fibrocutaneous Tags Any	Non Covered: Procedure/service not covered by the Plan.			
11200	Area; Up To And Including 15 Lesions	Not subject to pre-service review.	_	-	_
11201	Removal Of Skin Tags Multiple Fibrocutaneous Tags Any	Non Covered: Procedure/service not covered by the Plan.			
	Area; Each Additional 10 Lesions Or Part Thereof (List	·	_	_	_
	Separately In Addition To Code For Primary Procedure)	Not subject to pre-service review.			

	Tattooing Intradermal Introduction Of Insoluble Opaque	MP Criteria: Procedure/service reviewed against Medical			
11920	Pigments To Correct Color Defects Of Skin Including	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Micropigmentation; 6.0 Sq Cm Or Less	avoid post-service review.			
	Tattooing Intradermal Introduction Of Insoluble Opaque	MP Criteria: Procedure/service reviewed against Medical			
11921	Pigments To Correct Color Defects Of Skin Including	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Micropigmentation; 6.1 To 20.0 Sq Cm	avoid post-service review.			
	Tattooing Intradermal Introduction Of Insoluble Opaque				
	Pigments To Correct Color Defects Of Skin Including	MP Criteria: Procedure/service reviewed against Medical			
11922	Micropigmentation; Each Additional 20.0 Sq Cm Or Part	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Thereof (List Separately In Addition To Code For Primary	avoid post-service review.			
	Procedure)				
	Subcutaneous Injection Of Filling Material (Eg Collagen); 1	MP Criteria: Procedure/service reviewed against Medical			
11950	Cc Or Less	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Subcutaneous Injection Of Filling Material (Eg Collagen); 1.1	MP Criteria: Procedure/service reviewed against Medical			
11951	To 5.0 Cc	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Subcutaneous Injection Of Filling Material (Eg Collagen); 5.1	MP Criteria: Procedure/service reviewed against Medical			
11952	To 10.0 Cc	Policy Criteria. Submit for Recommended Clinical Review to	_		_
		avoid post-service review.			
	Subcutaneous Injection Of Filling Material (Eg Collagen);	MP Criteria: Procedure/service reviewed against Medical			
11954	Over 10.0 Cc	Policy Criteria. Submit for Recommended Clinical Review to	_		_
		avoid post-service review.			
	Insertion Of Tissue Expander(S) For Other Than Breast	MP Criteria: Procedure/service reviewed against Medical			
11960	Including Subsequent Expansion	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Replacement Of Tissue Expander With Permanent Implant	MP Criteria: Procedure/service reviewed against Medical			
11970		Policy Criteria. Submit for Recommended Clinical Review to	_		_
		avoid post-service review.			
	Subcutaneous Hormone Pellet Implantation (Implantation	MP Criteria: Procedure/service reviewed against Medical			
11980	Of Estradiol And/Or Testosterone Pellets Beneath The Skin)	Policy Criteria. Submit for Recommended Clinical Review to	_		_
	· · · · · · · · · · · · · · · · · · ·	avoid post-service review.			
	Application Of Skin Substitute Graft To Trunk Arms Legs	MP Criteria: Procedure/service reviewed against Medical			
15271	Total Wound Surface Area Up To 100 Sq Cm; First 25 Sq Cm	Policy Criteria. Submit for Recommended Clinical Review to	_		_
	Or Less Wound Surface Area	avoid post-service review.			
	Application Of Skin Substitute Graft To Trunk Arms Legs				
	Total Wound Surface Area Up To 100 Sq Cm; Each Additional	MP Criteria: Procedure/service reviewed against Medical			
15272	25 Sq Cm Wound Surface Area Or Part Thereof (List	Policy Criteria. Submit for Recommended Clinical Review to	_		_
	Separately In Addition To Code For Primary Procedure)	avoid post-service review.			
	Application Of Skin Substitute Graft To Trunk Arms Legs	MP Criteria: Procedure/service reviewed against Medical			
15273	Total Wound Surface Area Greater Than Or Equal To 100 Sq	Policy Criteria. Submit for Recommended Clinical Review to			
132/3	Cm; First 100 Sq Cm Wound Surface Area Or 1% Of Body	avoid post-service review.	_	-	-
	Area Of Infants And Children	avolu post-service review.			

15274	Application Of Skin Substitute Graft To Trunk Arms Legs Total Wound Surface Area Greater Than Or Equal To 100 Sq Cm; Each Additional 100 Sq Cm Wound Surface Area Or Part Thereof Or Each Additional 1% Of Body Area Of Infants And Children Or Part Thereof (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	-	-	-
15275	Application Of Skin Substitute Graft To Face Scalp Eyelids Mouth Neck Ears Orbits Genitalia Hands Feet And/Or Multiple Digits Total Wound Surface Area Up To 100 Sq Cm; First 25 Sq Cm Or Less Wound Surface Area	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	-	-	-
15276	Application Of Skin Substitute Graft To Face Scalp Eyelids Mouth Neck Ears Orbits Genitalia Hands Feet And/Or Multiple Digits Total Wound Surface Area Up To 100 Sq Cm; Each Additional 25 Sq Cm Wound Surface Area Or Part Thereof (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	-	-	_
15277	Application Of Skin Substitute Graft To Face Scalp Eyelids Mouth Neck Ears Orbits Genitalia Hands Feet And/Or Multiple Digits Total Wound Surface Area Greater Than Or Equal To 100 Sq Cm; First 100 Sq Cm Wound Surface Area Or 1% Of Body Area Of Infants And Children	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	-	-	-
15278	Application Of Skin Substitute Graft To Face Scalp Eyelids Mouth Neck Ears Orbits Genitalia Hands Feet And/Or Multiple Digits Total Wound Surface Area Greater Than Or Equal To 100 Sq Cm; Each Additional 100 Sq Cm Wound Surface Area Or Part Thereof Or Each Additional 1% Of Body Area Of Infants And Children Or Part Thereof (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	-	-	-
15758	Free Fascial Flap With Microvascular Anastomosis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	-	-
15769	Grafting Of Autologous Soft Tissue Other Harvested By Direct Excision (Eg Fat Dermis Fascia)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	-	-	-
15771	Grafting Of Autologous Fat Harvested By Liposuction Technique To Trunk Breasts Scalp Arms And/Or Legs; 50 Cc Or Less Injectate	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	-	-	-
15772	Grafting Of Autologous Fat Harvested By Liposuction Technique To Trunk Breasts Scalp Arms And/Or Legs; Each Additional 50 Cc Injectate Or Part Thereof (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	-	-	-
15775	Punch Graft For Hair Transplant; 1 To 15 Punch Grafts	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	-	-	-

	Punch Graft For Hair Transplant; More Than 15 Punch Grafts	MP Criteria: Procedure/service reviewed against Medical		
15776	rans. Graner or rian rransplant, more man 25 randir orang	Policy Criteria. Submit for Recommended Clinical Review to		
13770		avoid post-service review.	_	_
	Dermabrasion; Total Face (Eg For Acne Scarring Fine	MP Criteria: Procedure/service reviewed against Medical		
15780	Wrinkling Rhytids General Keratosis)	Policy Criteria. Submit for Recommended Clinical Review to		
	William g Milytius General Relacesis,	avoid post-service review.	_	_
	Dermabrasion; Segmental Face	MP Criteria: Procedure/service reviewed against Medical		
15781	bermasiasin, segmentar race	Policy Criteria. Submit for Recommended Clinical Review to		
10701		avoid post-service review.	_	_
	Dermabrasion; Regional Other Than Face	MP Criteria: Procedure/service reviewed against Medical		
15782	Sermanusian, negional saliei man lass	Policy Criteria. Submit for Recommended Clinical Review to		
23732		avoid post-service review.	_	_
	Dermabrasion; Superficial Any Site (Eg Tattoo Removal)	MP Criteria: Procedure/service reviewed against Medical		
15783	Jermaniasien, supernolar 7 m. y site (28 Tuttes nemetal,	Policy Criteria. Submit for Recommended Clinical Review to		
13703		avoid post-service review.	_	-
	Abrasion; Single Lesion (Eg Keratosis Scar)	MP Criteria: Procedure/service reviewed against Medical		
15786	Abrusion, single tesion (Eg. Retutosis Seur)	Policy Criteria. Submit for Recommended Clinical Review to		
13700		avoid post-service review.	-	-
	Abrasion; Each Additional 4 Lesions Or Less (List Separately	MP Criteria: Procedure/service reviewed against Medical		
15787	In Addition To Code For Primary Procedure)	Policy Criteria. Submit for Recommended Clinical Review to		
13767	in Addition to code for Filmary Frocedure,	avoid post-service review.	-	-
	Chemical Peel Facial; Epidermal	MP Criteria: Procedure/service reviewed against Medical		
15788	Chemical Feel Facial, Epidermai	Policy Criteria. Submit for Recommended Clinical Review to		
13700		avoid post-service review.	-	-
	Chemical Peel Facial; Dermal	MP Criteria: Procedure/service reviewed against Medical		
15789	chemical recirrudal, bernal	Policy Criteria. Submit for Recommended Clinical Review to		
13703		avoid post-service review.	_	_
	Chemical Peel Nonfacial; Epidermal	MP Criteria: Procedure/service reviewed against Medical		
15792	Chemical reel Nomacial, Epidermai	Policy Criteria. Submit for Recommended Clinical Review to		
13732		avoid post-service review.	-	-
	Chemical Peel Nonfacial; Dermal	MP Criteria: Procedure/service reviewed against Medical		+
15793	Chemical Feet Nomacial, Definal	Policy Criteria. Submit for Recommended Clinical Review to		
13733		avoid post-service review.	-	-
	Blepharoplasty Lower Eyelid;	MP Criteria: Procedure/service reviewed against Medical		
15820	Diepharopiasty Lower Lyena,	Policy Criteria. Submit for Recommended Clinical Review to		
13620		avoid post-service review.	-	_
	Blepharoplasty Lower Eyelid; With Extensive Herniated Fat	MP Criteria: Procedure/service reviewed against Medical		
15821	Pad	Policy Criteria. Submit for Recommended Clinical Review to		
15021	Pau	·	_	-
	Blepharoplasty Upper Eyelid;	avoid post-service review. MP Criteria: Procedure/service reviewed against Medical	+	
15822	biepliatopiasty Opper Eyellu;	Policy Criteria. Submit for Recommended Clinical Review to		
13822		'	-	-
	Blepharoplasty Upper Eyelid; With Excessive Skin Weighting	avoid post-service review. MB Critoria: Proceedure/service reviewed against Medical	+	
15022		I I		
15823	Down Lid	Policy Criteria. Submit for Recommended Clinical Review to	-	-
		avoid post-service review.		

	Rhytidectomy; Forehead	MP Criteria: Procedure/service reviewed against Medical			
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Policy Criteria. Submit for Recommended Clinical Review to			
15824		avoid post-service review. Prior Authorization may be	_		
		required per contract agreement.		1/31/2024	Retire effective 01/31/2024
	Rhytidectomy; Neck With Platysmal Tightening (Platysmal	MP Criteria: Procedure/service reviewed against Medical			
15825	Flap P-Flap)	Policy Criteria. Submit for Recommended Clinical Review to			
	- T - T - T - T - T - T - T - T - T - T	avoid post-service review.	_	_	_
	Rhytidectomy; Glabellar Frown Lines	MP Criteria: Procedure/service reviewed against Medical			
45006		Policy Criteria. Submit for Recommended Clinical Review to			
15826		avoid post-service review. Prior Authorization may be	_		
		required per contract agreement.		1/31/2024	Retire effective 01/31/2024
	Rhytidectomy; Cheek Chin And Neck	MP Criteria: Procedure/service reviewed against Medical			
15828		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Rhytidectomy; Superficial Musculoaponeurotic System	MP Criteria: Procedure/service reviewed against Medical			
15829	(Smas) Flap	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Excision Excessive Skin And Subcutaneous Tissue (Includes	MP Criteria: Procedure/service reviewed against Medical			
15830	Lipectomy); Abdomen Infraumbilical Panniculectomy	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Excision Excessive Skin And Subcutaneous Tissue (Includes	MP Criteria: Procedure/service reviewed against Medical			
15832	Lipectomy); Thigh	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Excision Excessive Skin And Subcutaneous Tissue (Includes	MP Criteria: Procedure/service reviewed against Medical			
15833	Lipectomy); Leg	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Excision Excessive Skin And Subcutaneous Tissue (Includes	MP Criteria: Procedure/service reviewed against Medical			
15834	Lipectomy); Hip	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Excision Excessive Skin And Subcutaneous Tissue (Includes	MP Criteria: Procedure/service reviewed against Medical			
15835	Lipectomy); Buttock	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Excision Excessive Skin And Subcutaneous Tissue (Includes	MP Criteria: Procedure/service reviewed against Medical			
15836	Lipectomy); Arm	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
45027	Excision Excessive Skin And Subcutaneous Tissue (Includes	MP Criteria: Procedure/service reviewed against Medical			
15837	Lipectomy); Forearm Or Hand	Policy Criteria. Submit for Recommended Clinical Review to	_	_	-
	5 5	avoid post-service review.			
15020	Excision Excessive Skin And Subcutaneous Tissue (Includes	MP Criteria: Procedure/service reviewed against Medical			
15838	Lipectomy); Submental Fat Pad	Policy Criteria. Submit for Recommended Clinical Review to	-	-	-
	Evolution Evolution Chin And Substitute Transaction In the Angel	avoid post-service review. MP Criteria: Procedure/service reviewed against Medical			
15020	Excision Excessive Skin And Subcutaneous Tissue (Includes				
15839	Lipectomy); Other Area	Policy Criteria. Submit for Recommended Clinical Review to	-	-	-
		avoid post-service review.			

	Excision Excessive Skin And Subcutaneous Tissue (Includes				
	Lipectomy) Abdomen (Eg Abdominoplasty) (Includes	MP Criteria: Procedure/service reviewed against Medical			
15847	Umbilical Transposition And Fascial Plication) (List	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Separately In Addition To Code For Primary Procedure)	avoid post-service review.			
	Suction Assisted Lipectomy; Head And Neck	MP Criteria: Procedure/service reviewed against Medical			
15876		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Suction Assisted Lipectomy; Trunk	MP Criteria: Procedure/service reviewed against Medical			
15877		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Suction Assisted Lipectomy; Upper Extremity	MP Criteria: Procedure/service reviewed against Medical			
15878		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Suction Assisted Lipectomy; Lower Extremity	MP Criteria: Procedure/service reviewed against Medical			
15879		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
15000	Unlisted Procedure Excision Pressure Ulcer	Unlisted: Procedure/service not specifically defined or			
15999		classified, maybe subject to contract/clinical review.	_	-	-
	Destruction Of Cutaneous Vascular Proliferative Lesions (Eg	MP Criteria: Procedure/service reviewed against Medical			
17106	Laser Technique); Less Than 10 Sq Cm	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Destruction Of Cutaneous Vascular Proliferative Lesions (Eg	MP Criteria: Procedure/service reviewed against Medical			
17107	Laser Technique); 10.0 To 50.0 Sq Cm	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Destruction Of Cutaneous Vascular Proliferative Lesions (Eg	MP Criteria: Procedure/service reviewed against Medical			
17108	Laser Technique); Over 50.0 Sq Cm	Policy Criteria. Submit for Recommended Clinical Review to	_		_
		avoid post-service review.			
	Cryotherapy (Co2 Slush Liquid N2) For Acne	EIU: Procedure/service not reimbursed by the Plan. Not			
17340		subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Chemical Exfoliation For Acne (Eg Acne Paste Acid)	MP Criteria: Procedure/service reviewed against Medical			
17360		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Electrolysis Epilation Each 30 Minutes	MP Criteria: Procedure/service reviewed against Medical			
17380		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
17999	Unlisted Procedure Skin Mucous Membrane And	Unlisted: Procedure/service not specifically defined or			
17999	Subcutaneous Tissue	classified, maybe subject to contract/clinical review.	_	_	-
	Ablation Cryosurgical Of Fibroadenoma Including	MP Criteria: Procedure/service reviewed against Medical			
19105	Ultrasound Guidance Each Fibroadenoma	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Preparation Of Tumor Cavity With Placement Of A Radiation	NAD Critoria: Proceedures (consisses reviewed accident NAC discu			
10204	Therapy Applicator For Intraoperative Radiation Therapy	MP Criteria: Procedures/services reviewed against Medical			
19294	(lort) Concurrent With Partial Mastectomy (List Separately In	Policy Criteria. Submit for Recommended Clinical Review to	_	-	-
	Addition To Code For Primary Procedure)	avoid post-service review by Carelon.			
					

	Placement Of Radiotherapy Afterloading Expandable			1	
	· · · · · · · · · · · · · · · · · · ·	MD Critoria, Dragoduras/sorvigas ravious diagnost Madical			
10206	Catheter (Single Or Multichannel) Into The Breast For	MP Criteria: Procedures/services reviewed against Medical			
19296	Interstitial Radioelement Application Following Partial	Policy Criteria. Submit for Recommended Clinical Review to	-	-	_
	Mastectomy Includes Imaging Guidance; On Date Separate	avoid post-service review by Carelon.			
	From Partial Mastectomy				
	Placement Of Radiotherapy Afterloading Expandable				
	Catheter (Single Or Multichannel) Into The Breast For	MP Criteria: Procedures/services reviewed against Medical			
19297	Interstitial Radioelement Application Following Partial	Policy Criteria. Submit for Recommended Clinical Review to			
	Mastectomy Includes Imaging Guidance; Concurrent With	avoid post-service review by Carelon.	_	_	_
	Partial Mastectomy (List Separately In Addition To Code For				
	Primary Procedure)				
	Placement Of Radiotherapy After Loading Brachytherapy				
	Catheters (Multiple Tube And Button Type) Into The Breast	MP Criteria: Procedures/services reviewed against Medical			
19298	For Interstitial Radioelement Application Following (At The	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Time Of Or Subsequent To) Partial Mastectomy Includes	avoid post-service review by Carelon.			
	Imaging Guidance				
	Mastectomy For Gynecomastia	MP Criteria: Procedure/service reviewed against Medical			
19300		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Mastectomy Simple Complete	MP Criteria: Procedure/service reviewed against Medical			
19303		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Mastopexy	MP Criteria: Procedure/service reviewed against Medical			
19316		Policy Criteria. Submit for Recommended Clinical Review to			
19310		avoid post-service review. Prior Authorization may be	_		
		required per contract agreement.		4/14/202	Retire effective 04/14/2024
	Breast Reduction	MP Criteria: Procedure/service reviewed against Medical			
19318		Policy Criteria. Submit for Recommended Clinical Review to			
19310		avoid post-service review. Prior Authorization may be	_		
		required per contract agreement.		1/31/202	Retire effective 01/31/2024
	Breast Augmentation With Implant	MP Criteria: Procedure/service reviewed against Medical			
19325		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Removal Of Intact Breast Implant	MP Criteria: Procedure/service reviewed against Medical			
19328		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Removal Of Ruptured Breast Implant Including Implant	MP Criteria: Procedure/service reviewed against Medical			
19330	Contents (Eg Saline Silicone Gel)	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Insertion Of Breast Implant On Same Day Of Mastectomy (le	MP Criteria: Procedure/service reviewed against Medical			
19340	Immediate)	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Insertion Or Replacement Of Breast Implant On Separate	MP Criteria: Procedure/service reviewed against Medical			
19342	Day From Mastectomy	Policy Criteria. Submit for Recommended Clinical Review to	_		_
		avoid post-service review.			1

	Nipple/Areola Reconstruction	MP Criteria: Procedure/service reviewed against Medical			
10250	Nippie/Areola Reconstruction				
19350		Policy Criteria. Submit for Recommended Clinical Review to	-	-	-
	0 11 001 1 111 1	avoid post-service review.			
10255	Correction Of Inverted Nipples	MP Criteria: Procedure/service reviewed against Medical			
19355		Policy Criteria. Submit for Recommended Clinical Review to	-	-	-
		avoid post-service review.			
	Tissue Expander Placement In Breast Reconstruction	MP Criteria: Procedure/service reviewed against Medical			
19357	Including Subsequent Expansion(S)	Policy Criteria. Submit for Recommended Clinical Review to	_	-	_
		avoid post-service review.			
	Revision Of Peri-Implant Capsule Breast Including	MP Criteria: Procedure/service reviewed against Medical			
19370	Capsulotomy Capsulorrhaphy And/Or Partial Capsulectomy	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Peri-Implant Capsulectomy Breast Complete Including	MP Criteria: Procedure/service reviewed against Medical			
19371	Removal Of All Intracapsular Contents	Policy Criteria. Submit for Recommended Clinical Review to		_	_
		avoid post-service review.			
	Unlisted Procedure Breast	MP Criteria: Procedure/service reviewed against Medical			
		Policy Criteria. Submit for Recommended Clinical Review to			
10400		avoid post-service review.			
19499		Unlisted or Undefined: Procedures/services not specifically	_	-	-
		defined or classified, maybe subject to contract/clinical			
		review.			
	Injection Enzyme (Eg Collagenase) Palmar Fascial Cord (Ie	MP Criteria: Procedure/service reviewed against Medical			
20527	Dupuytren'S Contracture)	Policy Criteria. Submit for Recommended Clinical Review to			
	, ,	avoid post-service review.	_		_
	Placement Of Needles Or Catheters Into Muscle And/Or Soft	·			
	Tissue For Subsequent Interstitial Radioelement Application	MP Criteria: Procedures/services reviewed against Medical			
20555	(At The Time Of Or Subsequent To The Procedure)	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	(te me time of or outsequent to me troccuure)	avoid post-service review by Carelon.			
	Needle Insertion(S) Without Injection(S); 1 Or 2 Muscle(S)	EIU: Procedure/service not reimbursed by the Plan. Not			
20560	, , , , , , , , , , , , , , , , , , ,	subject to pre-service review. Check EIU policy, which is			
20000		one of our Clinical Payment and Coding Policy (CPCP).	_	_	-
	Needle Insertion(S) Without Injection(S); 3 Or More Muscles				
20561	Theedic insertion(5) Without injection(5), 5 of More Musics	subject to pre-service review. Check EIU policy, which is			
20301		one of our Clinical Payment and Coding Policy (CPCP).	_	-	_
	Allograft Morselized Or Placement Of Osteopromotive	MP Criteria: Procedures/services reviewed against Medical			
20930	Material For Spine Surgery Only (List Separately In Addition	Policy Criteria. Submit for Recommended Clinical Review to			
20330		avoid post-service review by Carelon.	_	-	_
	To Code For Primary Procedure) Allograft Structural For Spine Surgery Only (List Separately	MP Criteria: Procedures/services reviewed against Medical			
20931		Policy Criteria. Submit for Recommended Clinical Review to			
20331	In Addition To Code For Primary Procedure)	·	_	-	-
	Alloweft Individes Townslating Cutting Discount And	avoid post-service review by Carelon.			
	Allograft Includes Templating Cutting Placement And	MP Criteria: Procedures/services reviewed against Medical			
20932	Internal Fixation When Performed; Osteoarticular Including	Policy Criteria. Submit for Recommended Clinical Review to	_		_
	Articular Surface And Contiguous Bone (List Separately In	avoid post-service review by Carelon.			
	Addition To Code For Primary Procedure)				

20933	Allograft Includes Templating Cutting Placement And Internal Fixation When Performed; Hemicortical Intercalary Partial (Ie Hemicylindrical) (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
20934	Allograft Includes Templating Cutting Placement And Internal Fixation When Performed; Intercalary Complete (Ie Cylindrical) (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
20936	Autograft For Spine Surgery Only (Includes Harvesting The Graft); Local (Eg Ribs Spinous Process Or Laminar Fragments) Obtained From Same Incision (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
20937	Autograft For Spine Surgery Only (Includes Harvesting The Graft); Morselized (Through Separate Skin Or Fascial Incision) (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
20938	Autograft For Spine Surgery Only (Includes Harvesting The Graft); Structural Bicortical Or Tricortical (Through Separate Skin Or Fascial Incision) (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
20939	Bone Marrow Aspiration For Bone Grafting Spine Surgery Only Through Separate Skin Or Fascial Incision (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
20974	Electrical Stimulation To Aid Bone Healing; Noninvasive (Nonoperative)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
20975	Electrical Stimulation To Aid Bone Healing; Invasive (Operative)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	-	_
20983	Ablation Therapy For Reduction Or Eradication Of 1 Or More Bone Tumors (Eg Metastasis) Including Adjacent Soft Tissue When Involved By Tumor Extension Percutaneous Including Imaging Guidance When Performed; Cryoablation		-	_	-
20985	Computer-Assisted Surgical Navigational Procedure For Musculoskeletal Procedures Image-Less (List Separately In Addition To Code For Primary Procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
20999	Unlisted Procedure Musculoskeletal System General	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	_
21073	Monitored Anesthesia Care)	avoid post-service review.	-	-	-
21083	Impression And Custom Preparation; Palatal Lift Prosthesis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	-	Add effective 04/01/2024

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	Impression And Custom Preparation; Oral Surgical Splint	MP Criteria: Procedures/services reviewed against Medical			
21085		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	10 10 10 10 10 10 10 10 10 10 10 10 10 1	avoid post-service review by BCBS.			
21089	Unlisted Maxillofacial Prosthetic Procedure	Unlisted: Procedure/service not specifically defined or			
		classified, maybe subject to contract/clinical review.	_		_
	Application Of Interdental Fixation Device For Conditions	MP Criteria: Procedures/services reviewed against Medical			
21110	Other Than Fracture Or Dislocation Includes Removal	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by BCBS.			
	Genioplasty; Augmentation (Autograft Allograft Prosthetic	MP Criteria: Procedure/service reviewed against Medical			
21120	Material)	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Genioplasty; Sliding Osteotomy Single Piece	MP Criteria: Procedure/service reviewed against Medical			
21121		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Genioplasty; Sliding Osteotomies 2 Or More Osteotomies	MP Criteria: Procedure/service reviewed against Medical			
21122	(Eg Wedge Excision Or Bone Wedge Reversal For	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Asymmetrical Chin)	avoid post-service review.			
	Genioplasty; Sliding Augmentation With Interpositional	MP Criteria: Procedure/service reviewed against Medical			
21123	Bone Grafts (Includes Obtaining Autografts)	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Augmentation Mandibular Body Or Angle; Prosthetic	MP Criteria: Procedure/service reviewed against Medical			
21125	Material	Policy Criteria. Submit for Recommended Clinical Review to			
21123		avoid post-service review. Prior Authorization may be	_		
		required per contract agreement.		4/14/2024	Retire effective 04/14/2024
		MP Criteria: Procedure/service reviewed against Medical			
21127	Onlay Or Interpositional (Includes Obtaining Autograft)	Policy Criteria. Submit for Recommended Clinical Review to			
21127		avoid post-service review. Prior Authorization may be	_		
		required per contract agreement.		4/14/2024	Retire effective 04/14/2024
	Reconstruction Midface Lefort I; Single Piece Segment	MP Criteria: Procedures/services reviewed against Medical			
21141	Movement In Any Direction (Eg For Long Face Syndrome)	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Without Bone Graft	avoid post-service review by BCBS.			
	Reconstruction Midface Lefort I; 2 Pieces Segment	MP Criteria: Procedures/services reviewed against Medical			
21142	Movement In Any Direction Without Bone Graft	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by BCBS.			
	Reconstruction Midface Lefort I; 3 Or More Pieces Segment	MP Criteria: Procedures/services reviewed against Medical			
21143	Movement In Any Direction Without Bone Graft	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by BCBS.			
	Reconstruction Midface Lefort I; Single Piece Segment	MP Criteria: Procedure/service reviewed against Medical			
21145	Movement In Any Direction Requiring Bone Grafts (Includes	Policy Criteria. Submit for Recommended Clinical Review to			
	Obtaining Autografts)	avoid post-service review. Prior Authorization may be	-	-	_
		required per contract agreement.			
	Reconstruction Midface Lefort I; 2 Pieces Segment	MP Criteria: Procedure/service reviewed against Medical			
21146	Movement In Any Direction Requiring Bone Grafts (Includes	Policy Criteria. Submit for Recommended Clinical Review to			
21146	Obtaining Autografts) (Eg Ungrafted Unilateral Alveolar	avoid post-service review. Prior Authorization may be	-	-	-
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21194 Or L Osteotomy; With Bone Graft (Includes Obtaining Graft) Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. Reconstruction Of Mandibular Rami And/Or Body Sagittal Split; Without Internal Rigid Fixation Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. Reconstruction Of Mandibular Rami And/Or Body Sagittal Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. Reconstruction Of Mandibular Rami And/Or Body Sagittal Split; With Internal Rigid Fixation Policy Criteria. Submit for Recommended Clinical Review to Policy Criteria.			avoid post-service review by BCBS.			
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avoid post-service review by BCBS. Reconstruction Of Mandibular Rami And/Or Body Sagittal Split; Without Internal Rigid Fixation Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. Reconstruction Of Mandibular Rami And/Or Body Sagittal Split; With Internal Rigid Fixation Policy Criteria. Submit for Recommended Guincal Review to Split; With Internal Rigid Fixation Policy Criteria. Submit for Recommended Clinical Review to Split; With Internal Rigid Fixation Policy Criteria. Submit for Recommended Clinical Review to Split; With Internal Rigid Fixation Avoid post-service review by BCBS. MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to Split; With Internal Rigid Fixation	21194	Or L Osteotomy; With Bone Graft (Includes Obtaining Graft)	Policy Criteria. Submit for Recommended Clinical Review to	_		
Reconstruction Of Mandibular Rami And/Or Body Sagittal Split; Without Internal Rigid Fixation Policy Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. Reconstruction Of Mandibular Rami And/Or Body Sagittal MP Criteria: Procedures/services reviewed against Medical MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to Split; With Internal Rigid Fixation Policy Criteria. Submit for Recommended Clinical Review to — — — — — — — — — — — — — — — — — — —		,, ,	avoid post-service review by BCBS.	_		_
21195 Split; Without Internal Rigid Fixation Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. Reconstruction Of Mandibular Rami And/Or Body Sagittal MP Criteria: Procedures/services reviewed against Medical Split; With Internal Rigid Fixation Policy Criteria. Submit for Recommended Clinical Review to		Reconstruction Of Mandibular Rami And/Or Body Sagittal				
avoid post-service review by BCBS. Reconstruction Of Mandibular Rami And/Or Body Sagittal Policy Criteria. Submit for Recommended Clinical Review to Policy Criteria.	21195					
Reconstruction Of Mandibular Rami And/Or Body Sagittal 21196 Split; With Internal Rigid Fixation Policy Criteria. Submit for Recommended Clinical Review to		Spire, Without Internal Night Heation	·	-	-	-
21196 Split; With Internal Rigid Fixation Policy Criteria. Submit for Recommended Clinical Review to		Poconstruction Of Mandibular Pami And/Or Pody Socittal			 	
	21106	, ,	·			
layoid post-service review by BCBS.	Z1130	Split; with internal Rigid Fixation	·	-	-	-
			· · · · · · · · · · · · · · · · · · ·			
Osteotomy Mandible Segmental; MP Criteria: Procedures/services reviewed against Medical		Osteotomy Mandible Segmental;				
21198 Policy Criteria. Submit for Recommended Clinical Review to	21198		•	_	_	-
avoid post-service review by BCBS.			avoid post-service review by BCBS.			

	Osteotomy Mandible Segmental; With Genioglossus	MP Criteria: Procedures/services reviewed against Medical			
21199	Advancement	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by BCBS.			
	Osteotomy Maxilla Segmental (Eg Wassmund Or	MP Criteria: Procedure/service reviewed against Medical			
24206	Schuchard)	Policy Criteria. Submit for Recommended Clinical Review to			
21206		avoid post-service review. Prior Authorization may be	-	_	_
		required per contract agreement.			
	Osteoplasty Facial Bones; Augmentation (Autograft	MP Criteria: Procedure/service reviewed against Medical			
	Allograft Or Prosthetic Implant)	Policy Criteria. Submit for Recommended Clinical Review to			
21208	7 mograte of 1 rostilette implanty	avoid post-service review. Prior Authorization may be	_	_	_
		required per contract agreement.			
	Osteoplasty Facial Bones; Reduction	MP Criteria: Procedure/service reviewed against Medical			
	Osteoplasty Taciai Bolles, Reduction	Policy Criteria. Submit for Recommended Clinical Review to			
21209		· ·	_	_	_
		avoid post-service review. Prior Authorization may be			
		required per contract agreement.			
	Graft Bone; Nasal Maxillary Or Malar Areas (Includes	MP Criteria: Procedures/services reviewed against Medical			
21210	Obtaining Graft)	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by BCBS.			
	Graft Bone; Mandible (Includes Obtaining Graft)	MP Criteria: Procedures/services reviewed against Medical			
21215		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by BCBS.			
	Graft; Rib Cartilage Autogenous To Face Chin Nose Or Ear	MP Criteria: Procedures/services reviewed against Medical			
21230	(Includes Obtaining Graft)	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by BCBS.			
	Reconstruction Of Mandible Extraoral With Transosteal	MP Criteria: Procedure/service reviewed against Medical			
21244	Bone Plate (Eg Mandibular Staple Bone Plate)	Policy Criteria. Submit for Recommended Clinical Review to		_	
		avoid post-service review.	4/1/2024		Add effective 04/01/2024
	Reconstruction Of Mandible Or Maxilla Subperiosteal	MP Criteria: Procedure/service reviewed against Medical			
21245	Implant; Partial	Policy Criteria. Submit for Recommended Clinical Review to		_	
		avoid post-service review.	4/1/2024		Add effective 04/01/2024
	Reconstruction Of Mandible Or Maxilla Subperiosteal	MP Criteria: Procedure/service reviewed against Medical			
21246	Implant; Complete	Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review.	4/1/2024	_	Add effective 04/01/2024
	Reconstruction Of Mandible Or Maxilla Endosteal Implant	Non Covered: Procedure/service not covered by the Plan.	, , -		
21248	(Eg Blade Cylinder); Partial	Not subject to pre-service review.	_	_	_
	Reconstruction Of Mandible Or Maxilla Endosteal Implant	Non Covered: Procedure/service not covered by the Plan.			
21249	(Eg Blade Cylinder); Complete	Not subject to pre-service review.	_	_	_
	Unlisted Craniofacial And Maxillofacial Procedure	Unlisted: Procedure/service not specifically defined or			
21299	Offilisted Craffioracial Affa Maxilloracial Procedure		_	_	_
	Halistad M. condesinated Duncadous Hood	classified, maybe subject to contract/clinical review.			
21499	Unlisted Musculoskeletal Procedure Head	Unlisted: Procedure/service not specifically defined or	_	_	
	Haridaa atau atau atau	classified, maybe subject to contract/clinical review.			
	Hyoid Myotomy And Suspension	MP Criteria: Procedure/service reviewed against Medical			
21685		Policy Criteria. Submit for Recommended Clinical Review to	_	_	-
		avoid post-service review.			
21899	Unlisted Procedure Neck Or Thorax	Unlisted: Procedure/service not specifically defined or			
		classified, maybe subject to contract/clinical review.	_	_	_

	Osteotomy Of Spine Posterior Or Posterolateral Approach 3	MP Criteria: Procedures/services reviewed against Medical			
22206	Columns 1 Vertebral Segment (Eg Pedicle/Vertebral Body	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Subtraction); Thoracic	avoid post-service review by Carelon.			
	Osteotomy Of Spine Posterior Or Posterolateral Approach 3	MP Criteria: Procedures/services reviewed against Medical			
22207	Columns 1 Vertebral Segment (Eg Pedicle/Vertebral Body	Policy Criteria. Submit for Recommended Clinical Review to	_		_
	Subtraction); Lumbar	avoid post-service review by Carelon.			
	Osteotomy Of Spine Posterior Or Posterolateral Approach 3				
	Columns 1 Vertebral Segment (Eg Pedicle/Vertebral Body	MP Criteria: Procedures/services reviewed against Medical			
22208	Subtraction); Each Additional Vertebral Segment (List	Policy Criteria. Submit for Recommended Clinical Review to			
	Separately In Addition To Code For Primary Procedure)	avoid post-service review by Carelon.	_		_
		' '			
	Osteotomy Of Spine Posterior Or Posterolateral Approach 1	MP Criteria: Procedures/services reviewed against Medical			
22210	Vertebral Segment; Cervical	Policy Criteria. Submit for Recommended Clinical Review to	_		
	,	avoid post-service review by Carelon.	_		Γ
	Osteotomy Of Spine Posterior Or Posterolateral Approach 1	MP Criteria: Procedures/services reviewed against Medical			
22212	Vertebral Segment; Thoracic	Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review by Carelon.	_	_	<u> </u>
	Osteotomy Of Spine Posterior Or Posterolateral Approach 1	MP Criteria: Procedures/services reviewed against Medical			
22214	Vertebral Segment; Lumbar	Policy Criteria. Submit for Recommended Clinical Review to			
	tertestaroegment, zamos.	avoid post-service review by Carelon.	_	_	-
	Osteotomy Of Spine Posterior Or Posterolateral Approach 1	MP Criteria: Procedures/services reviewed against Medical			
22216		Policy Criteria. Submit for Recommended Clinical Review to			
	Separately In Addition To Primary Procedure)	avoid post-service review by Carelon.	_	_	-
	Osteotomy Of Spine Including Discectomy Anterior	MP Criteria: Procedures/services reviewed against Medical			
22220	Approach Single Vertebral Segment; Cervical	Policy Criteria. Submit for Recommended Clinical Review to			
	Approudit single vertestal segment, cervical	avoid post-service review by Carelon.	_	_	-
	Osteotomy Of Spine Including Discectomy Anterior	MP Criteria: Procedures/services reviewed against Medical			1
22222	Approach Single Vertebral Segment; Thoracic	Policy Criteria. Submit for Recommended Clinical Review to			
22222	Approach Single Vertebrai Segment, Moracic	avoid post-service review by Carelon.	_	-	-
	Osteotomy Of Spine Including Discectomy Anterior	MP Criteria: Procedures/services reviewed against Medical			
22224	Approach Single Vertebral Segment; Lumbar	Policy Criteria. Submit for Recommended Clinical Review to			
22224	Approach Single Vertebrai Segment, Lumbai	avoid post-service review by Carelon.	_	-	-
	Osteotomy Of Spine Including Discectomy Anterior				
	Approach Single Vertebral Segment; Each Additional	MP Criteria: Procedures/services reviewed against Medical			
22226	Vertebral Segment (List Separately In Addition To Code For	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Primary Procedure)	avoid post-service review by Carelon.			
	Manipulation Of Spine Requiring Anesthesia Any Region	MP Criteria: Procedure/service reviewed against Medical			
22505	Manipulation of Spine Requiring Allestriesia Arry Region	Policy Criteria. Submit for Recommended Clinical Review to			
22303		avoid post-service review.	_	-	-
	Percutaneous Vertebroplasty (Bone Biopsy Included When				+
	Performed) 1 Vertebral Body Unilateral Or Bilateral	MP Criteria: Procedures/services reviewed against Medical			
22510	Injection Inclusive Of All Imaging Guidance; Cervicothoracic	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	injection inclusive of All imaging duludnice, Cervicothoracic	avoid post-service review by Carelon.			
	Percutaneous Vertebroplasty (Bone Biopsy Included When	MP Criteria: Procedures/services reviewed against Medical			+
22511	Performed) 1 Vertebral Body Unilateral Or Bilateral	Policy Criteria. Submit for Recommended Clinical Review to			
	Injection Inclusive Of All Imaging Guidance; Lumbosacral	avoid post-service review by Carelon.	_	-	-
	injection inclusive of All imaging duluance, Lumbosacial	avoid post service review by carefoli.			

		T. C.	1	1	
	Percutaneous Vertebroplasty (Bone Biopsy Included When				
	Performed) 1 Vertebral Body Unilateral Or Bilateral	MP Criteria: Procedures/services reviewed against Medical			
22512	Injection Inclusive Of All Imaging Guidance; Each Additional	Policy Criteria. Submit for Recommended Clinical Review to			
	Cervicothoracic Or Lumbosacral Vertebral Body (List	avoid post-service review by Carelon.	_	_	-
	Separately In Addition To Code For Primary Procedure)	arona post ser nee remen sy earenonn			
	Percutaneous Vertebral Augmentation Including Cavity				
	Creation (Fracture Reduction And Bone Biopsy Included	MP Criteria: Procedures/services reviewed against Medical			
22513	When Performed) Using Mechanical Device (Eg	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Kyphoplasty) 1 Vertebral Body Unilateral Or Bilateral	avoid post-service review by Carelon.			
	Cannulation Inclusive Of All Imaging Guidance; Thoracic				
	Percutaneous Vertebral Augmentation Including Cavity				
	Creation (Fracture Reduction And Bone Biopsy Included	MP Criteria: Procedures/services reviewed against Medical			
22514	When Performed) Using Mechanical Device (Eg	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Kyphoplasty) 1 Vertebral Body Unilateral Or Bilateral	avoid post-service review by Carelon.			
	Cannulation Inclusive Of All Imaging Guidance; Lumbar				
	Percutaneous Vertebral Augmentation Including Cavity				
	Creation (Fracture Reduction And Bone Biopsy Included				
	When Performed) Using Mechanical Device (Eg	MP Criteria: Procedures/services reviewed against Medical			
22515	Kyphoplasty) 1 Vertebral Body Unilateral Or Bilateral	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Cannulation Inclusive Of All Imaging Guidance; Each	avoid post-service review by Carelon.			
	Additional Thoracic Or Lumbar Vertebral Body (List				
	Separately In Addition To Code For Primary Procedure)				
	Percutaneous Intradiscal Electrothermal Annuloplasty	EIU: Procedure/service not reimbursed by the Plan. Not			
22526	Unilateral Or Bilateral Including Fluoroscopic Guidance;	subject to pre-service review. Check EIU policy, which is	_	_	_
	Single Level	one of our Clinical Payment and Coding Policy (CPCP).			
	Percutaneous Intradiscal Electrothermal Annuloplasty	EIU: Procedure/service not reimbursed by the Plan. Not			
22527	Unilateral Or Bilateral Including Fluoroscopic Guidance; 1 Or	subject to pre-service review. Check EIU policy, which is			
22327	More Additional Levels (List Separately In Addition To Code	one of our Clinical Payment and Coding Policy (CPCP).	_	-	_
	For Primary Procedure)				
	Arthrodesis Lateral Extracavitary Technique Including	MP Criteria: Procedures/services reviewed against Medical			
22532	Minimal Discectomy To Prepare Interspace (Other Than For	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Decompression); Thoracic	avoid post-service review by Carelon.			
	Arthrodesis Lateral Extracavitary Technique Including	MP Criteria: Procedures/services reviewed against Medical			
22533	Minimal Discectomy To Prepare Interspace (Other Than For	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Decompression); Lumbar	avoid post-service review by Carelon.			
	Arthrodesis Lateral Extracavitary Technique Including				
	Minimal Discectomy To Prepare Interspace (Other Than For	MP Criteria: Procedures/services reviewed against Medical			
22534	Decompression); Thoracic Or Lumbar Each Additional	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Vertebral Segment (List Separately In Addition To Code For	avoid post-service review by Carelon.			
	Primary Procedure)				
	Arthrodesis Anterior Transoral Or Extraoral Technique	MP Criteria: Procedures/services reviewed against Medical			
22548	Clivus-C1-C2 (Atlas-Axis) With Or Without Excision Of	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Odontoid Process	avoid post-service review by Carelon.			

22551	Arthrodesis Anterior Interbody Including Disc Space Preparation Discectomy Osteophytectomy And	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to			
22331	Decompression Of Spinal Cord And/Or Nerve Roots; Cervical Below C2	avoid post-service review by Carelon.	_	_	-
	Arthrodesis Anterior Interbody Including Disc Space				
	Preparation Discectomy Osteophytectomy And	MP Criteria: Procedures/services reviewed against Medical			
22552	Decompression Of Spinal Cord And/Or Nerve Roots; Cervical	•			
22332		avoid post-service review by Carelon.	_	-	_
	Below C2 Each Additional Interspace (List Separately In	avolu post-service review by Carelon.			
	Addition To Code For Primary Procedure) Arthrodesis Anterior Interbody Technique Including	MP Criteria: Procedures/services reviewed against Medical			
22554		Policy Criteria. Submit for Recommended Clinical Review to			
22554	Minimal Discectomy To Prepare Interspace (Other Than For	· ·	-	-	_
	Decompression); Cervical Below C2 Arthrodesis Anterior Interbody Technique Including	avoid post-service review by Carelon. MP Criteria: Procedures/services reviewed against Medical			
2255		_			
22556	Minimal Discectomy To Prepare Interspace (Other Than For	Policy Criteria. Submit for Recommended Clinical Review to	-	-	
	Decompression); Thoracic	avoid post-service review by Carelon.			
	Arthrodesis Anterior Interbody Technique Including	MP Criteria: Procedures/services reviewed against Medical			
22558	Minimal Discectomy To Prepare Interspace (Other Than For	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Decompression); Lumbar	avoid post-service review by Carelon.			
	Arthrodesis Anterior Interbody Technique Including	MP Criteria: Procedures/services reviewed against Medical			
22585	Minimal Discectomy To Prepare Interspace (Other Than For	Policy Criteria. Submit for Recommended Clinical Review to			
	Decompression); Each Additional Interspace (List Separately	avoid post-service review by Carelon.	_	_	_
	In Addition To Code For Primary Procedure)	avoid post service review by careform			
	Arthrodesis Pre-Sacral Interbody Technique Including Disc	EIU: Procedure/service not reimbursed by the Plan. Not			
22586	Space Preparation Discectomy With Posterior	subject to pre-service review. Check EIU policy, which is			
22300	Instrumentation With Image Guidance Includes Bone Graft	one of our Clinical Payment and Coding Policy (CPCP).	_	-	_
	When Performed L5-S1 Interspace	one of our chinear ayment and coding toney (cret).			
	Arthrodesis Posterior Technique Craniocervical (Occiput-	MP Criteria: Procedures/services reviewed against Medical			
22590	C2)	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by Carelon.			
	Arthrodesis Posterior Technique Atlas-Axis (C1-C2)	MP Criteria: Procedures/services reviewed against Medical			
22595		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by Carelon.			
	Arthrodesis Posterior Or Posterolateral Technique Single	MP Criteria: Procedures/services reviewed against Medical			
22600	Interspace; Cervical Below C2 Segment	Policy Criteria. Submit for Recommended Clinical Review to	_		
		avoid post-service review by Carelon.			
	Arthrodesis Posterior Or Posterolateral Technique Single	MP Criteria: Procedures/services reviewed against Medical			
22610	Interspace; Thoracic (With Lateral Transverse Technique	Policy Criteria. Submit for Recommended Clinical Review to			
	When Performed)	avoid post-service review by Carelon.	_	_	_
	Arthrodesis Posterior Or Posterolateral Technique Single	MP Criteria: Procedures/services reviewed against Medical			
22612	Interspace; Lumbar (With Lateral Transverse Technique	Policy Criteria. Submit for Recommended Clinical Review to			
	When Performed)	avoid post-service review by Carelon.	_	_	 -
	Arthrodesis Posterior Or Posterolateral Technique Single	MP Criteria: Procedures/services reviewed against Medical			
22614	Interspace; Each Additional Interspace (List Separately In	Policy Criteria. Submit for Recommended Clinical Review to			
	Addition To Code For Primary Procedure)	avoid post-service review by Carelon.	-	-	-
	[Addition to code for Fillidly Flocedule)	avoid post service review by carefoli.	<u> </u>	1	1

	Arthrodesis Posterior Interbody Technique Including	MP Criteria: Procedures/services reviewed against Medical			
22522	Laminectomy And/Or Discectomy To Prepare Interspace	·			
22630	(Other Than For Decompression) Single Interspace Lumbar;	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	(other man of becompression, single interspace Edinbar,	avoid post-service review by Carelon.			
	Arthrodesis Posterior Interbody Technique Including				
	Laminectomy And/Or Discectomy To Prepare Interspace	MP Criteria: Procedures/services reviewed against Medical			
22632	(Other Than For Decompression) Single Interspace Lumbar;	•			
22032		avoid post-service review by Carelon.	-	_	_
	Each Additional Interspace (List Separately In Addition To	avoid post-service review by Careion.			
	Code For Primary Procedure)				
	Arthrodesis Combined Posterior Or Posterolateral				
	Technique With Posterior Interbody Technique Including	MP Criteria: Procedures/services reviewed against Medical			
22633	Laminectomy And/Or Discectomy Sufficient To Prepare	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Interspace (Other Than For Decompression) Single	avoid post-service review by Carelon.			
	Interspace Lumbar;				
	Arthrodesis Combined Posterior Or Posterolateral				
	Technique With Posterior Interbody Technique Including				
	Laminectomy And/Or Discectomy Sufficient To Prepare	MP Criteria: Procedures/services reviewed against Medical			
22634		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Interspace (Other Than For Decompression) Single	avoid post-service review by Carelon.			
	Interspace Lumbar; Each Additional Interspace (List				
	Separately In Addition To Code For Primary Procedure)	14B G 11 1 B 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			
	Arthrodesis Posterior For Spinal Deformity With Or	MP Criteria: Procedures/services reviewed against Medical			
22800	Without Cast; Up To 6 Vertebral Segments	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by Carelon.			
	Arthrodesis Posterior For Spinal Deformity With Or	MP Criteria: Procedures/services reviewed against Medical			
22802	Without Cast; 7 To 12 Vertebral Segments	Policy Criteria. Submit for Recommended Clinical Review to	_		_
	_	avoid post-service review by Carelon.			
	Arthrodesis Posterior For Spinal Deformity With Or	MP Criteria: Procedures/services reviewed against Medical			
22804	Without Cast; 13 Or More Vertebral Segments	Policy Criteria. Submit for Recommended Clinical Review to			
	Without Gast, 15 St. More Vertestal Seg. Ments	avoid post-service review by Carelon.	_	_	_
	Arthrodesis Anterior For Spinal Deformity With Or Without				
22808					
22000	Cast; 2 To 3 Vertebral Segments	Policy Criteria. Submit for Recommended Clinical Review to	-	_	_
		avoid post-service review by Carelon.			
	Arthrodesis Anterior For Spinal Deformity With Or Without				
22810	Cast; 4 To 7 Vertebral Segments	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by Carelon.			
	Arthrodesis Anterior For Spinal Deformity With Or Without	MP Criteria: Procedures/services reviewed against Medical			
22812	Cast; 8 Or More Vertebral Segments	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	_	avoid post-service review by Carelon.			
	Kyphectomy Circumferential Exposure Of Spine And	MP Criteria: Procedures/services reviewed against Medical			
22818	Resection Of Vertebral Segment(S) (Including Body And	Policy Criteria. Submit for Recommended Clinical Review to			
	Posterior Elements); Single Or 2 Segments	avoid post-service review by Carelon.	_	_	_
	Kyphectomy Circumferential Exposure Of Spine And	MP Criteria: Procedures/services reviewed against Medical			
22010		·			
22819	Resection Of Vertebral Segment(S) (Including Body And	Policy Criteria. Submit for Recommended Clinical Review to	-	-	-
	Posterior Elements); 3 Or More Segments	avoid post-service review by Carelon.			
	Exploration Of Spinal Fusion	MP Criteria: Procedures/services reviewed against Medical			
22830		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by Carelon.			

	Autorian Thomasia Vantabual Dady Tathanian Industria	EIU: Procedure/service not reimbursed by the Plan. Not		1	
	Anterior Thoracic Vertebral Body Tethering Including				
22836	Thoracoscopy When Performed; Up To 7 Vertebral	subject to pre-service review. Check EIU policy, which is	_ / /	_	
	Segments	one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024		Add effective 05/15/2024
	Anterior Thoracic Vertebral Body Tethering Including	MP Criteria: Procedure/service reviewed against Medical			
22836	Thoracoscopy When Performed; Up To 7 Vertebral	Policy Criteria. Submit for Recommended Clinical Review to			Add effective 02/15/2024
	Segments	avoid post-service review.	2/15/2024	5/14/2024	Retire effective 05/14/2024
	Anterior Thoracic Vertebral Body Tethering Including	EIU: Procedure/service not reimbursed by the Plan. Not			
22837	Thoracoscopy When Performed; 8 Or More Vertebral	subject to pre-service review. Check EIU policy, which is			
	Segments	one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024		Add effective 05/15/2024
	Anterior Thoracic Vertebral Body Tethering Including	MP Criteria: Procedure/service reviewed against Medical			
22837	Thoracoscopy When Performed; 8 Or More Vertebral	Policy Criteria. Submit for Recommended Clinical Review to			Add effective 02/15/2024
	Segments	avoid post-service review.	2/15/2024	5/14/2024	Retire effective 05/14/2024
	Revision (Eg. Augmentation Division Of Tether)	EIU: Procedure/service not reimbursed by the Plan. Not			
22838	Replacement Or Removal Of Thoracic Vertebral Body	subject to pre-service review. Check EIU policy, which is			
	Tethering Including Thoracoscopy When Performed	one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	-	Add effective 05/15/2024
	Revision (Eg Augmentation Division Of Tether)	MP Criteria: Procedure/service reviewed against Medical	3/ 23/ 202 :		7100 01100010 007 107 101 1
22838	Replacement Or Removal Of Thoracic Vertebral Body	Policy Criteria. Submit for Recommended Clinical Review to			Add effective 02/15/2024
22030	· ·	· ·	2/15/2024	5/14/2024	Retire effective 05/14/2024
	Tethering Including Thoracoscopy When Performed	avoid post-service review.	2/13/2024	3/14/2024	Retire effective 03/14/2024
	Posterior Non-Segmental Instrumentation (Eg Harrington	NAD Criteria. Dressed rass/services reviewed assistat NAsdisel			
22040	Rod Technique Pedicle Fixation Across 1 Interspace	MP Criteria: Procedures/services reviewed against Medical			
22840	Atlantoaxial Transarticular Screw Fixation Sublaminar	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Wiring At C1 Facet Screw Fixation) (List Separately In	avoid post-service review by Carelon.			
	Addition To Code For Primary Procedure)				
	Internal Spinal Fixation By Wiring Of Spinous Processes (List	MP Criteria: Procedures/services reviewed against Medical			
22841	Separately In Addition To Code For Primary Procedure)	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by Carelon.			
	Posterior Segmental Instrumentation (Eg Pedicle Fixation	MP Criteria: Procedures/services reviewed against Medical			
22842	Dual Rods With Multiple Hooks And Sublaminar Wires); 3 To	Policy Criteria. Submit for Recommended Clinical Review to			
22012	6 Vertebral Segments (List Separately In Addition To Code	avoid post-service review by Carelon.	_	_	_
	For Primary Procedure)	avoid post-service review by Carelon.			
	Posterior Segmental Instrumentation (Eg Pedicle Fixation	MP Criteria: Procedures/services reviewed against Medical			
22843	Dual Rods With Multiple Hooks And Sublaminar Wires); 7 To	Policy Criteria. Submit for Recommended Clinical Review to			
22043	12 Vertebral Segments (List Separately In Addition To Code	· ·	_	_	_
	For Primary Procedure)	avoid post-service review by Carelon.			
	Posterior Segmental Instrumentation (Eg Pedicle Fixation	NAD Criteria: Dragaduras/services reviewed against Nasdiesl			
22044	Dual Rods With Multiple Hooks And Sublaminar Wires); 13	MP Criteria: Procedures/services reviewed against Medical			
22844	Or More Vertebral Segments (List Separately In Addition To	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Code For Primary Procedure)	avoid post-service review by Carelon.			
	Anterior Instrumentation; 2 To 3 Vertebral Segments (List	MP Criteria: Procedures/services reviewed against Medical			
22845	Separately In Addition To Code For Primary Procedure)	Policy Criteria. Submit for Recommended Clinical Review to			
	Separatery in reading in the season of the initially the season of	avoid post-service review by Carelon.	_	_	_
	Anterior Instrumentation; 4 To 7 Vertebral Segments (List	MP Criteria: Procedures/services reviewed against Medical			
22846	Separately In Addition To Code For Primary Procedure)	Policy Criteria. Submit for Recommended Clinical Review to			
220.0	Separately in Addition to code for Filmary Flocedure)	avoid post-service review by Carelon.	-	-	-
	Anterior Instrumentation; 8 Or More Vertebral Segments	MP Criteria: Procedures/services reviewed against Medical			
22847	·	Policy Criteria. Submit for Recommended Clinical Review to			
2204/	(List Separately In Addition To Code For Primary Procedure)	· ·	-	-	-
		avoid post-service review by Carelon.			

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22848	Pelvic Fixation (Attachment Of Caudal End Of Instrumentation To Pelvic Bony Structures) Other Than Sacrum (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	
22849	Reinsertion Of Spinal Fixation Device	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	-	-
22853	Insertion Of Interbody Biomechanical Device(S) (Eg Synthetic Cage Mesh) With Integral Anterior Instrumentation For Device Anchoring (Eg Screws Flanges) When Performed To Intervertebral Disc Space In Conjunction With Interbody Arthrodesis Each Interspace (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
22854	Insertion Of Intervertebral Biomechanical Device(S) (Eg Synthetic Cage Mesh) With Integral Anterior Instrumentation For Device Anchoring (Eg Screws Flanges) When Performed To Vertebral Corpectomy(Ies) (Vertebral Body Resection Partial Or Complete) Defect In Conjunction With Interbody Arthrodesis Each Contiguous Defect (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
22856	Total Disc Arthroplasty (Artificial Disc) Anterior Approach Including Discectomy With End Plate Preparation (Includes Osteophytectomy For Nerve Root Or Spinal Cord Decompression And Microdissection); Single Interspace Cervical	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
22857	Total Disc Arthroplasty (Artificial Disc) Anterior Approach Including Discectomy To Prepare Interspace (Other Than For Decompression); Single Interspace Lumbar	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
22858	Total Disc Arthroplasty (Artificial Disc) Anterior Approach Including Discectomy With End Plate Preparation (Includes Osteophytectomy For Nerve Root Or Spinal Cord Decompression And Microdissection); Second Level Cervical (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	-	-
22859	Insertion Of Intervertebral Biomechanical Device(S) (Eg Synthetic Cage Mesh Methylmethacrylate) To Intervertebral Disc Space Or Vertebral Body Defect Without Interbody Arthrodesis Each Contiguous Defect (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
22860	Total Disc Arthroplasty (Artificial Disc) Anterior Approach Including Discectomy To Prepare Interspace (Other Than For Decompression); Second Interspace Lumbar (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-

	Revision Including Replacement Of Total Disc Arthroplasty	MP Criteria: Procedures/services reviewed against Medical			
22861	(Artificial Disc) Anterior Approach Single Interspace;	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Cervical	avoid post-service review by Carelon.			
	Revision Including Replacement Of Total Disc Arthroplasty	MP Criteria: Procedures/services reviewed against Medical			
22862	(Artificial Disc) Anterior Approach Single Interspace;	Policy Criteria. Submit for Recommended Clinical Review to			
	Lumbar	avoid post-service review by Carelon.	_	_	_
	Removal Of Total Disc Arthroplasty (Artificial Disc) Anterior	MP Criteria: Procedures/services reviewed against Medical			
22864		Policy Criteria. Submit for Recommended Clinical Review to			
22004	Approach Single Interspace; Cervical	·	-	_	-
	D 1007 + 10; A - 1 - 1 - 1 - 1 - 1 - 1 - 1	avoid post-service review by Carelon.			
	Removal Of Total Disc Arthroplasty (Artificial Disc) Anterior	MP Criteria: Procedures/services reviewed against Medical			
22865	Approach Single Interspace; Lumbar	Policy Criteria. Submit for Recommended Clinical Review to	-	_	_
		avoid post-service review by Carelon.			
	Insertion Of Interlaminar/Interspinous Process	EIU: Procedure/service not reimbursed by the Plan. Not			
22867	Stabilization/Distraction Device Without Fusion Including	subject to pre-service review. Check EIU policy, which is			
22007	Image Guidance When Performed With Open		-	-	-
	Decompression Lumbar; Single Level	one of our Clinical Payment and Coding Policy (CPCP).			
	Insertion Of Interlaminar/Interspinous Process				
	Stabilization/Distraction Device Without Fusion Including	EIU: Procedure/service not reimbursed by the Plan. Not			
22868	Image Guidance When Performed With Open	subject to pre-service review. Check EIU policy, which is			
22000	·		-	-	-
	Decompression Lumbar; Second Level (List Separately In	one of our Clinical Payment and Coding Policy (CPCP).			
	Addition To Code For Primary Procedure)				
	Insertion Of Interlaminar/Interspinous Process	EIU: Procedure/service not reimbursed by the Plan. Not			
22869	Stabilization/Distraction Device Without Open	subject to pre-service review. Check EIU policy, which is			
	Decompression Or Fusion Including Image Guidance When	one of our Clinical Payment and Coding Policy (CPCP).	_	-	_
	Performed Lumbar; Single Level	one of our chinicart ayment and country to they (cricily.			
	Insertion Of Interlaminar/Interspinous Process				
	Stabilization/Distraction Device Without Open	EIU: Procedure/service not reimbursed by the Plan. Not			
22870	Decompression Or Fusion Including Image Guidance When	subject to pre-service review. Check EIU policy, which is			
	Performed Lumbar; Second Level (List Separately In	one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
	Addition To Code For Primary Procedure)	, , , , , , , , , , , , , , , , , , ,			
	Unlisted Procedure Spine	Unlisted: Procedure/service not specifically defined or			
22899	offisted Procedure Spirie	classified, maybe subject to contract/clinical review.	_	_	_
	Unlisted Presedure Abdomon Museulaskalatal Custom	Unlisted: Procedure/service not specifically defined or			
22999	Unlisted Procedure Abdomen Musculoskeletal System	· · · · ·	_	_	_
		classified, maybe subject to contract/clinical review.			
	Arthrotomy; Glenohumeral Joint With Synovectomy With	MP Criteria: Procedures/services reviewed against Medical			
23105	Or Without Biopsy	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by Carelon.			
	Arthrotomy Glenohumeral Joint With Joint Exploration	MP Criteria: Procedures/services reviewed against Medical			
23107	With Or Without Removal Of Loose Or Foreign Body	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by Carelon.			
	Claviculectomy; Partial	MP Criteria: Procedures/services reviewed against Medical			
23120	, , , , , , , , , , , , , , , , , , ,	Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review by Carelon.	_	_	-
	Repair Of Ruptured Musculotendinous Cuff (Eg Rotator	MP Criteria: Procedures/services reviewed against Medical			+
23410		Policy Criteria. Submit for Recommended Clinical Review to			
25410	Cuff) Open; Acute	·	-	-	-
		avoid post-service review by Carelon.			

	Repair Of Ruptured Musculotendinous Cuff (Eg Rotator	MP Criteria: Procedures/services reviewed against Medical			
23412	Cuff) Open; Chronic	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by Carelon.			
	Coracoacromial Ligament Release With Or Without	MP Criteria: Procedures/services reviewed against Medical			
23415	Acromioplasty	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by Carelon.			
	Reconstruction Of Complete Shoulder (Rotator) Cuff	MP Criteria: Procedures/services reviewed against Medical			
23420	Avulsion Chronic (Includes Acromioplasty)	Policy Criteria. Submit for Recommended Clinical Review to	_		_
	, , , , , , , , , , , , , , , , , , , ,	avoid post-service review by Carelon.			
	Tenodesis Of Long Tendon Of Biceps	MP Criteria: Procedures/services reviewed against Medical			
23430		Policy Criteria. Submit for Recommended Clinical Review to			_
		avoid post-service review by Carelon.	_		_
	Resection Or Transplantation Of Long Tendon Of Biceps	MP Criteria: Procedures/services reviewed against Medical			
23440	·	Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review by Carelon.	_	_	_
	Capsulorrhaphy Anterior; Putti-Platt Procedure Or	MP Criteria: Procedures/services reviewed against Medical			
23450	Magnuson Type Operation	Policy Criteria. Submit for Recommended Clinical Review to			
	, reserve the shortmen	avoid post-service review by Carelon.	_	_	_
	Capsulorrhaphy Anterior; With Labral Repair (Eg Bankart	MP Criteria: Procedures/services reviewed against Medical			
23455	Procedure)	Policy Criteria. Submit for Recommended Clinical Review to			
	i i occasi cy	avoid post-service review by Carelon.	_	_	-
	Capsulorrhaphy Anterior Any Type; With Bone Block	MP Criteria: Procedures/services reviewed against Medical			
23460	capsulottiapity vinterior viny type, that some slook	Policy Criteria. Submit for Recommended Clinical Review to			
25 .55		avoid post-service review by Carelon.	_	_	-
	Capsulorrhaphy Anterior Any Type; With Coracoid Process	MP Criteria: Procedures/services reviewed against Medical			
23462	Transfer	Policy Criteria. Submit for Recommended Clinical Review to			
25 .52	Tunsier	avoid post-service review by Carelon.	_	_	-
	Capsulorrhaphy Glenohumeral Joint Posterior With Or	MP Criteria: Procedures/services reviewed against Medical			
23465	Without Bone Block	Policy Criteria. Submit for Recommended Clinical Review to			
25 .65	Without Bone Block	avoid post-service review by Carelon.	_	_	-
	Capsulorrhaphy Glenohumeral Joint Any Type	MP Criteria: Procedures/services reviewed against Medical			
23466	Multidirectional Instability	Policy Criteria. Submit for Recommended Clinical Review to			
23 100	Waltan ectional mistability	avoid post-service review by Carelon.	_	_	_
	Arthroplasty Glenohumeral Joint; Hemiarthroplasty	MP Criteria: Procedures/services reviewed against Medical			
23470	A thropiasty dienonumeral John, Hermarthropiasty	Policy Criteria. Submit for Recommended Clinical Review to			
25470		avoid post-service review by Carelon.	_	-	_
	Arthroplasty Glenohumeral Joint; Total Shoulder (Glenoid	MP Criteria: Procedures/services reviewed against Medical			
23472	And Proximal Humeral Replacement (Eg. Total Shoulder))	Policy Criteria. Submit for Recommended Clinical Review to			
25472	And Froximal numeral Replacement (Lg Total Shoulder))	avoid post-service review by Carelon.	_	-	_
	Revision Of Total Shoulder Arthroplasty Including Allograft	MP Criteria: Procedures/services reviewed against Medical			
23473		Policy Criteria. Submit for Recommended Clinical Review to			
25475	When Performed; Humeral Or Glenoid Component	·	_	_	_
	Povicion Of Total Shoulder Arthroplacty, Including Allegraft	avoid post-service review by Carelon. MP Criteria: Procedures/services reviewed against Medical		+	
22474	Revision Of Total Shoulder Arthroplasty Including Allograft				
23474	When Performed; Humeral And Glenoid Component	Policy Criteria. Submit for Recommended Clinical Review to	_	-	-
	Manipulation Haden Appethants Charleton to the P	avoid post-service review by Carelon.			Moved from PA to
22700	Manipulation Under Anesthesia Shoulder Joint Including	MP Criteria: Procedures/services reviewed against Medical	1 /1 /2024		Recommended Clinical Review
23700	Application Of Fixation Apparatus (Dislocation Excluded)	Policy Criteria. Submit for Recommended Clinical Review to	1/1/2024	-	
		avoid post-service review by Carelon.			01/01/2024

	Unlisted Procedure Shoulder	MP Criteria: Procedure/service reviewed against Medical			
		Policy Criteria. Submit for Recommended Clinical Review to			
23929		avoid post-service review.			
23929		Unlisted or Undefined: Procedures/services not specifically	-	-	-
		defined or classified, maybe subject to contract/clinical			
		review.			
	Manipulation Elbow Under Anesthesia	MP Criteria: Procedure/service reviewed against Medical			
24300		Policy Criteria. Submit for Recommended Clinical Review to	_		_
		avoid post-service review.			
24000	Unlisted Procedure Humerus Or Elbow	Unlisted: Procedure/service not specifically defined or			
24999		classified, maybe subject to contract/clinical review.	-	-	_
	Manipulation Wrist Under Anesthesia	MP Criteria: Procedure/service reviewed against Medical			
25259		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
25000	Unlisted Procedure Forearm Or Wrist	Unlisted: Procedure/service not specifically defined or			
25999		classified, maybe subject to contract/clinical review.	-	-	_
	Manipulation Finger Joint Under Anesthesia Each Joint	MP Criteria: Procedure/service reviewed against Medical			
26340		Policy Criteria. Submit for Recommended Clinical Review to	_		
		avoid post-service review.			
	Manipulation Palmar Fascial Cord (le Dupuytren'S Cord)	MP Criteria: Procedure/service reviewed against Medical			
26341	Post Enzyme Injection (Eg. Collagenase) Single Cord	Policy Criteria. Submit for Recommended Clinical Review to			
	, , , , , , , ,	avoid post-service review.	_		
25222	Unlisted Procedure Hands Or Fingers	Unlisted: Procedure/service not specifically defined or			
26989	, and the second	classified, maybe subject to contract/clinical review.	_	-	_
	Injection Procedure For Sacroiliac Joint Anesthetic/Steroid	MP Criteria: Procedures/services reviewed against Medical			
27096	With Image Guidance (Fluoroscopy Or Ct) Including	Policy Criteria. Submit for Recommended Clinical Review to	_		
	Arthrography When Performed	avoid post-service review by Carelon.			
	Acetabuloplasty; (Eg Whitman Colonna Haygroves Or Cup				
27120	Type)	Policy Criteria. Submit for Recommended Clinical Review to			
	, ,	avoid post-service review by Carelon.	_		_
	Acetabuloplasty; Resection Femoral Head (Eg. Girdlestone	MP Criteria: Procedures/services reviewed against Medical			
27122	Procedure)	Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review by Carelon.	_	_	_
	Hemiarthroplasty Hip Partial (Eg Femoral Stem Prosthesis	MP Criteria: Procedures/services reviewed against Medical			
27125	Bipolar Arthroplasty)	Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review by Carelon.	_	_	_
	Arthroplasty Acetabular And Proximal Femoral Prosthetic	MP Criteria: Procedures/services reviewed against Medical			
27130	Replacement (Total Hip Arthroplasty) With Or Without	Policy Criteria. Submit for Recommended Clinical Review to			
	Autograft Or Allograft	avoid post-service review by Carelon.	_	_	_
	Conversion Of Previous Hip Surgery To Total Hip	MP Criteria: Procedures/services reviewed against Medical			
27132	Arthroplasty With Or Without Autograft Or Allograft	Policy Criteria. Submit for Recommended Clinical Review to			
	The second secon	avoid post-service review by Carelon.	_	_	<u></u>
	Revision Of Total Hip Arthroplasty; Both Components With	MP Criteria: Procedures/services reviewed against Medical			1
27134	Or Without Autograft Or Allograft	Policy Criteria. Submit for Recommended Clinical Review to			
	of William Autograft of Allograft	avoid post-service review by Carelon.	-	-	-
		avoid post-service review by Carelott.			ļ.

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	Revision Of Total Hip Arthroplasty; Acetabular Component	MP Criteria: Procedures/services reviewed against Medical			
27137	Only With Or Without Autograft Or Allograft	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by Carelon.			
	Revision Of Total Hip Arthroplasty; Femoral Component	MP Criteria: Procedures/services reviewed against Medical			
27138	Only With Or Without Allograft	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by Carelon.			
	Manipulation Hip Joint Requiring General Anesthesia	MP Criteria: Procedure/service reviewed against Medical			
27275		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Arthrodesis Sacroiliac Joint Percutaneous With Image				
27278	Guidance Including Placement Of Intra-Articular Implant(S)	EIU: Procedure/service not reimbursed by the Plan. Not			
2,2,0	(Eg Bone Allograft[S] Synthetic Device[S]) Without	subject to pre-service review. Check EIU policy, which is		-	
	Placement Of Transfixation Device	one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024		Add effective 05/15/2024
	Arthrodesis Sacroiliac Joint Percutaneous With Image	MP Criteria: Procedure/service reviewed against Medical			
27278	Guidance Including Placement Of Intra-Articular Implant(S)	Policy Criteria. Submit for Recommended Clinical Review to			
2,2,0	(Eg Bone Allograft[S] Synthetic Device[S]) Without	avoid post-service review.			Add effective 02/15/2024
	Placement Of Transfixation Device	avoid post service review.	2/15/2024	5/14/2024	Retire effective 05/14/2024
	Arthrodesis Sacroiliac Joint Percutaneous Or Minimally	MP Criteria: Procedures/services reviewed against Medical			
27279	Invasive (Indirect Visualization) With Image Guidance	Policy Criteria. Submit for Recommended Clinical Review to			
2,2,3	Includes Obtaining Bone Graft When Performed And	avoid post-service review by Carelon.	-	-	_
	Placement Of Transfixing Device	· ·			
	Arthrodesis Sacroiliac Joint Open Includes Obtaining Bone	MP Criteria: Procedures/services reviewed against Medical			
27280	Graft Including Instrumentation When Performed	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by BCBS.			
	Unlisted Procedure Pelvis Or Hip Joint	MP Criteria: Procedure/service reviewed against Medical			
		Policy Criteria. Submit for Recommended Clinical Review to			
27299		avoid post-service review.			
27233		Unlisted or Undefined: Procedures/services not specifically	-	-	_
		defined or classified, maybe subject to contract/clinical			
		review.			
	Arthrotomy Knee; Including Joint Exploration Biopsy Or	MP Criteria: Procedures/services reviewed against Medical			Moved from PA to
27331	Removal Of Loose Or Foreign Bodies	Policy Criteria. Submit for Recommended Clinical Review to	1/1/2024	_	Recommended Clinical Review
		avoid post-service review by Carelon.			01/01/2024
	Arthrotomy With Excision Of Semilunar Cartilage	MP Criteria: Procedures/services reviewed against Medical			
27332	(Meniscectomy) Knee; Medial Or Lateral	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by Carelon.			
	Arthrotomy With Excision Of Semilunar Cartilage	MP Criteria: Procedures/services reviewed against Medical			
27333	(Meniscectomy) Knee; Medial And Lateral	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by Carelon.			
	Arthrotomy With Synovectomy Knee; Anterior Or Posterior				
27334		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by Carelon.			
	Arthrotomy With Synovectomy Knee; Anterior And	MP Criteria: Procedures/services reviewed against Medical			
27335	Posterior Including Popliteal Area	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by Carelon.			

	Excision Of Synovial Cyst Of Popliteal Space (Eg Baker'S	MP Criteria: Procedures/services reviewed against Medical			
27345	Cyst)	Policy Criteria. Submit for Recommended Clinical Review to			
	9,50,	avoid post-service review by Carelon.	-	_	-
	Arthrotomy With Meniscus Repair Knee	MP Criteria: Procedures/services reviewed against Medical			
27403	The motority with members repair times	Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review by Carelon.	-	_	-
	Repair Primary Torn Ligament And/Or Capsule Knee;	MP Criteria: Procedures/services reviewed against Medical			Moved from PA to
27405	Collateral	Policy Criteria. Submit for Recommended Clinical Review to	1/1/2024		Recommended Clinical Review
	Conditional	avoid post-service review by Carelon.	_, _,	_	01/01/2024
	Repair Primary Torn Ligament And/Or Capsule Knee;	MP Criteria: Procedures/services reviewed against Medical			Moved from PA to
27407	Cruciate	Policy Criteria. Submit for Recommended Clinical Review to	1/1/2024		Recommended Clinical Review
	o. asiate	avoid post-service review by Carelon.	_, _,	_	01/01/2024
	Repair Primary Torn Ligament And/Or Capsule Knee;	MP Criteria: Procedures/services reviewed against Medical			Moved from PA to
27409	Collateral And Cruciate Ligaments	Policy Criteria. Submit for Recommended Clinical Review to	1/1/2024		Recommended Clinical Review
		avoid post-service review by Carelon.	, , -	_	01/01/2024
	Osteochondral Allograft Knee Open	MP Criteria: Procedures/services reviewed against Medical			
27415		Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review by Carelon.	-	<u></u>	_
	Osteochondral Autograft(S) Knee Open (Eg Mosaicplasty)	MP Criteria: Procedures/services reviewed against Medical			
27416	(Includes Harvesting Of Autograft[S])	Policy Criteria. Submit for Recommended Clinical Review to			
	(avoid post-service review by Carelon.	-	_	_
	Lateral Retinacular Release Open	MP Criteria: Procedures/services reviewed against Medical			
27425	· ·	Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review by Carelon.	-	_	_
	Ligamentous Reconstruction (Augmentation) Knee; Extra-	MP Criteria: Procedures/services reviewed against Medical			
27427	Articular	Policy Criteria. Submit for Recommended Clinical Review to	_		
		avoid post-service review by Carelon.			
	Ligamentous Reconstruction (Augmentation) Knee; Intra-	MP Criteria: Procedures/services reviewed against Medical			
27428	Articular (Open)	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by Carelon.			
	Ligamentous Reconstruction (Augmentation) Knee; Intra-	MP Criteria: Procedures/services reviewed against Medical			
27429	Articular (Open) And Extra-Articular	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by Carelon.			
	Arthroplasty Patella; Without Prosthesis	MP Criteria: Procedures/services reviewed against Medical			
27437		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by Carelon.			
	Arthroplasty Patella; With Prosthesis	MP Criteria: Procedures/services reviewed against Medical			
27438		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by Carelon.			
	Arthroplasty Knee Tibial Plateau;	MP Criteria: Procedures/services reviewed against Medical			
27440		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by Carelon.			
	Arthroplasty Knee Tibial Plateau; With Debridement And	MP Criteria: Procedures/services reviewed against Medical			
27441	Partial Synovectomy	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by Carelon.			
	Arthroplasty Femoral Condyles Or Tibial Plateau(S) Knee;	MP Criteria: Procedures/services reviewed against Medical			
27442		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by Carelon.			

	Arthroplasty Femoral Condyles Or Tibial Plateau(S) Knee;	MP Criteria: Procedures/services reviewed against Medical			
27443	With Debridement And Partial Synovectomy	Policy Criteria. Submit for Recommended Clinical Review to	_		_
		avoid post-service review by Carelon.			
	Arthroplasty Knee Hinge Prosthesis (Eg Walldius Type)	MP Criteria: Procedures/services reviewed against Medical			
27445		Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review by Carelon.	_	_	-
	Arthroplasty Knee Condyle And Plateau; Medial Or Lateral	MP Criteria: Procedures/services reviewed against Medical			
27446		·			
27446	Compartment	Policy Criteria. Submit for Recommended Clinical Review to	-	-	_
		avoid post-service review by Carelon.			
	Arthroplasty Knee Condyle And Plateau; Medial And Lateral				
27447	Compartments With Or Without Patella Resurfacing (Total	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Knee Arthroplasty)	avoid post-service review by Carelon.			
	Revision Of Total Knee Arthroplasty With Or Without	MP Criteria: Procedures/services reviewed against Medical			
27486	Allograft; 1 Component	Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review by Carelon.			
	Revision Of Total Knee Arthroplasty With Or Without	MP Criteria: Procedures/services reviewed against Medical			
27487	Allograft; Femoral And Entire Tibial Component	Policy Criteria. Submit for Recommended Clinical Review to			
21401	Allogiant, Temoral And Entire Tibial Component	avoid post-service review by Carelon.	-	-	_
	Dansaral Of Breathasia Including Tatal Knop Breathasia	MP Criteria: Procedures/services reviewed against Medical			
	Removal Of Prosthesis Including Total Knee Prosthesis	·			
27488	Methylmethacrylate With Or Without Insertion Of Spacer	Policy Criteria. Submit for Recommended Clinical Review to	-	_	_
	Knee	avoid post-service review by Carelon.			
27599	Unlisted Procedure Femur Or Knee	Unlisted: Procedure/service not specifically defined or			
27333		classified, maybe subject to contract/clinical review.	-	-	_
	Arthroplasty Ankle; Revision Total Ankle	MP Criteria: Procedure/service reviewed against Medical			
27703		Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review.	_		_
	Manipulation Of Ankle Under General Anesthesia (Includes	MP Criteria: Procedure/service reviewed against Medical			
27860	Application Of Traction Or Other Fixation Apparatus)	Policy Criteria. Submit for Recommended Clinical Review to			
27000	Application of Traction of Other Fixation Apparatus)	avoid post-service review.	-	-	-
	Halisted Basedone Lee On Amble	·			
27899	Unlisted Procedure Leg Or Ankle	Unlisted: Procedure/service not specifically defined or			
		classified, maybe subject to contract/clinical review.		_	_
	Open Osteochondral Autograft Talus (Includes Obtaining	MP Criteria: Procedures/services reviewed against Medical			
28446	Graft[S])	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by Carelon.			
	Extracorporeal Shock Wave High Energy Performed By A	FILL Dragadura/sarviga not raimbursad by the Dlan Not			
2000	Physician Or Other Qualified Health Care Professional	EIU: Procedure/service not reimbursed by the Plan. Not			
28890	Requiring Anesthesia Other Than Local Including Ultrasound	subject to pre-service review. Check EIU policy, which is	-	_	_
	Guidance Involving The Plantar Fascia	one of our Clinical Payment and Coding Policy (CPCP).			
	Unlisted Procedure Foot Or Toes	Unlisted: Procedure/service not specifically defined or			
28899	omisted Hocedule Tool of Toes	· · · · · · · · · · · · · · · · · · ·	_	_	_
	Adding Mallion To Duning of Assistant Cont	classified, maybe subject to contract/clinical review.			
29440	Adding Walker To Previously Applied Cast	Non Covered: Procedure/service not covered by the Plan.			
		Not subject to pre-service review.			
29799	Unlisted Procedure Casting Or Strapping	Unlisted: Procedure/service not specifically defined or			
		classified, maybe subject to contract/clinical review.	-	_	_
	Arthroscopy Shoulder Diagnostic With Or Without Synovial	MP Criteria: Procedures/services reviewed against Medical			Moved from PA to
29805	Biopsy (Separate Procedure)	Policy Criteria. Submit for Recommended Clinical Review to	1/1/2024	L	Recommended Clinical Review
		avoid post-service review by Carelon.			01/01/2024
29805	Biopsy (Separate Procedure)	·	1/1/2024	-	

	Arthroscopy Shoulder Surgical; Capsulorrhaphy	MP Criteria: Procedures/services reviewed against Medical		Moved fror	n PA to
29806		Policy Criteria. Submit for Recommended Clinical Review to	1/1/2024	Recommen	ded Clinical Review
		avoid post-service review by Carelon.		01/01/2024	4
	Arthroscopy Shoulder Surgical; Repair Of Slap Lesion	MP Criteria: Procedures/services reviewed against Medical		Moved fror	n PA to
29807		Policy Criteria. Submit for Recommended Clinical Review to	1/1/2024	_ Recommen	ided Clinical Review
		avoid post-service review by Carelon.		01/01/2024	4
	Arthroscopy Shoulder Surgical; With Removal Of Loose	MP Criteria: Procedures/services reviewed against Medical		Moved fror	n PA to
29819	Body Or Foreign Body	Policy Criteria. Submit for Recommended Clinical Review to	1/1/2024	_ Recommen	ided Clinical Review
		avoid post-service review by Carelon.		01/01/2024	
	Arthroscopy Shoulder Surgical; Synovectomy Partial	MP Criteria: Procedures/services reviewed against Medical		Moved fror	n PA to
29820		Policy Criteria. Submit for Recommended Clinical Review to	1/1/2024	<u> </u>	ided Clinical Review
		avoid post-service review by Carelon.		01/01/2024	
	Arthroscopy Shoulder Surgical; Synovectomy Complete	MP Criteria: Procedures/services reviewed against Medical		Moved fror	
29821		Policy Criteria. Submit for Recommended Clinical Review to	1/1/2024	<u> </u>	ided Clinical Review
		avoid post-service review by Carelon.		01/01/2024	4
	Arthroscopy Shoulder Surgical; Debridement Limited 1 Or				
	2 Discrete Structures (Eg Humeral Bone Humeral Articular				
	Cartilage Glenoid Bone Glenoid Articular Cartilage Biceps	MP Criteria: Procedures/services reviewed against Medical			
29822	Tendon Biceps Anchor Complex Labrum Articular Capsule	Policy Criteria. Submit for Recommended Clinical Review to	1/1/2024	-	
	Articular Side Of The Rotator Cuff Bursal Side Of The Rotator	avoid post-service review by Carelon.		Moved fror	
	Cuff Subacromial Bursa Foreign Body[les])				ided Clinical Review
				01/01/2024	4
	Arthroscopy Shoulder Surgical; Debridement Extensive 3				
	Or More Discrete Structures (Eg Humeral Bone Humeral				
2002	A mineral continuage of chief a point of chief a first continuage		4 /4 /2024		
29823	Biceps Tendon Biceps Anchor Complex Labrum Articular	Policy Criteria. Submit for Recommended Clinical Review to	1/1/2024	_ Moved fror	m DA +o
	Capsule Articular Side Of The Rotator Cuff Bursal Side Of	avoid post-service review by Carelon.			
	The Rotator Cuff Subacromial Bursa Foreign Body[les])			01/01/2024	ided Clinical Review
	Authorosous Chaulden Consisal, Distal Clavia destaus	MP Criteria: Procedures/services reviewed against Medical		Moved from	
29824	Arthroscopy Shoulder Surgical; Distal Claviculectomy	Policy Criteria. Submit for Recommended Clinical Review to	1/1/2024		ided Clinical Review
23024	Including Distal Articular Surface (Mumford Procedure)	avoid post-service review by Carelon.	1/1/2024	01/01/2024	
	Arthroscopy Shoulder Surgical; With Lysis And Resection Of	MP Criteria: Procedures/services reviewed against Medical		Moved from	
29825	Adhesions With Or Without Manipulation	Policy Criteria. Submit for Recommended Clinical Review to	1/1/2024		ided Clinical Review
23023	Autresions with or without Manipulation	avoid post-service review by Carelon.	1/1/2021	01/01/2024	
	Arthroscopy Shoulder Surgical; Decompression Of	avoid post service review by earcion.		5-7-2-7-2-2	
	Subacromial Space With Partial Acromioplasty With	MP Criteria: Procedures/services reviewed against Medical			
29826	Coracoacromial Ligament (le Arch) Release When	Policy Criteria. Submit for Recommended Clinical Review to	1/1/2024	Moved from	n PA to
	Performed (List Separately In Addition To Code For Primary	avoid post-service review by Carelon.	-, -, :	– Recommen	ided Clinical Review
	Procedure)	, , , , , , , , , , , , , , , , , , , ,		01/01/2024	4
	Arthroscopy Shoulder Surgical; With Rotator Cuff Repair	MP Criteria: Procedures/services reviewed against Medical		Moved from	
29827	,,	Policy Criteria. Submit for Recommended Clinical Review to	1/1/2024	_ Recommen	ded Clinical Review
		avoid post-service review by Carelon.		01/01/2024	4
	Arthroscopy Shoulder Surgical; Biceps Tenodesis	MP Criteria: Procedures/services reviewed against Medical		Moved fror	n PA to
29828		Policy Criteria. Submit for Recommended Clinical Review to	1/1/2024	_ Recommen	ded Clinical Review
		avoid post-service review by Carelon.		01/01/2024	4

	Arthroscopy Hip Diagnostic With Or Without Synovial	MP Criteria: Procedures/services reviewed against Medical			Moved from PA to
29860	Biopsy (Separate Procedure)	Policy Criteria. Submit for Recommended Clinical Review to	1/1/2024		Recommended Clinical Review
	., (,	avoid post-service review by Carelon.		_	01/01/2024
	Arthroscopy Hip Surgical; With Removal Of Loose Body Or	MP Criteria: Procedures/services reviewed against Medical			Moved from PA to
29861	Foreign Body	Policy Criteria. Submit for Recommended Clinical Review to	1/1/2024		Recommended Clinical Review
		avoid post-service review by Carelon.		_	01/01/2024
	Arthroscopy Hip Surgical; With Debridement/Shaving Of	MP Criteria: Procedures/services reviewed against Medical			Moved from PA to
29862	Articular Cartilage (Chondroplasty) Abrasion Arthroplasty	Policy Criteria. Submit for Recommended Clinical Review to	1/1/2024		Recommended Clinical Review
	And/Or Resection Of Labrum	avoid post-service review by Carelon.		_	01/01/2024
	Arthroscopy Hip Surgical; With Synovectomy	MP Criteria: Procedures/services reviewed against Medical			Moved from PA to
29863		Policy Criteria. Submit for Recommended Clinical Review to	1/1/2024		Recommended Clinical Review
		avoid post-service review by Carelon.		_	01/01/2024
	Arthroscopy Knee Surgical; Osteochondral Autograft(S) (Eg				
	Mosaicplasty) (Includes Harvesting Of The Autograft[S])	MP Criteria: Procedures/services reviewed against Medical			Moved from PA to
29866	1 // 0 0 1 //	Policy Criteria. Submit for Recommended Clinical Review to	_	_	Recommended Clinical Review
		avoid post-service review by BCBS.			01/01/2024
	Arthroscopy Knee Surgical; Osteochondral Autograft(S) (Eg	MP Criteria: Procedure/service reviewed against Medical			
29866	Mosaicplasty) (Includes Harvesting Of The Autograft[S])	Policy Criteria. Submit for Recommended Clinical Review to			
	1 // 0 0 1 //	avoid post-service review.	_	_	_
	Arthroscopy Knee Surgical; Osteochondral Allograft (Eg	MP Criteria: Procedures/services reviewed against Medical			Moved from PA to
29867	Mosaicplasty)	Policy Criteria. Submit for Recommended Clinical Review to	1/1/2024	L	Recommended Clinical Review
		avoid post-service review by Carelon.			01/01/2024
	Arthroscopy Knee Surgical; Osteochondral Allograft (Eg	MP Criteria: Procedure/service reviewed against Medical			
29867	Mosaicplasty)	Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review.	2/15/2024		Add effective 02/15/2024
	Arthroscopy Knee Surgical; Meniscal Transplantation	MP Criteria: Procedures/services reviewed against Medical			Moved from PA to
29868	(Includes Arthrotomy For Meniscal Insertion) Medial Or	Policy Criteria. Submit for Recommended Clinical Review to	1/1/2024	L	Recommended Clinical Review
	Lateral	avoid post-service review by Carelon.			01/01/2024
	Arthroscopy Knee Diagnostic With Or Without Synovial	MP Criteria: Procedures/services reviewed against Medical			Moved from PA to
29870	Biopsy (Separate Procedure)	Policy Criteria. Submit for Recommended Clinical Review to	1/1/2024	_	Recommended Clinical Review
		avoid post-service review by Carelon.			01/01/2024
	Arthroscopy Knee Surgical; For Infection Lavage And	MP Criteria: Procedures/services reviewed against Medical			Moved from PA to
29871	Drainage	Policy Criteria. Submit for Recommended Clinical Review to	1/1/2024	_	Recommended Clinical Review
		avoid post-service review by Carelon.			01/01/2024
	Arthroscopy Knee Surgical; With Lateral Release	MP Criteria: Procedures/services reviewed against Medical			Moved from PA to
29873		Policy Criteria. Submit for Recommended Clinical Review to	1/1/2024	_	Recommended Clinical Review
		avoid post-service review by Carelon.			01/01/2024
	Arthroscopy Knee Surgical; For Removal Of Loose Body Or	MP Criteria: Procedures/services reviewed against Medical			Moved from PA to
29874	Foreign Body (Eg Osteochondritis Dissecans Fragmentation	Policy Criteria. Submit for Recommended Clinical Review to	1/1/2024		Recommended Clinical Review
	Chondral Fragmentation)	avoid post-service review by Carelon.			01/01/2024
	Arthroscopy Knee Surgical; Synovectomy Limited (Eg Plica	MP Criteria: Procedures/services reviewed against Medical			Moved from PA to
29875	Or Shelf Resection) (Separate Procedure)	Policy Criteria. Submit for Recommended Clinical Review to	1/1/2024		Recommended Clinical Review
		avoid post-service review by Carelon.			01/01/2024
	Arthroscopy Knee Surgical; Synovectomy Major 2 Or More				Moved from PA to
29876	Compartments (Eg Medial Or Lateral)	Policy Criteria. Submit for Recommended Clinical Review to	1/1/2024	L	Recommended Clinical Review
			To the second se	The second secon	01/01/2024

	Arthroscopy Knee Surgical; Debridement/Shaving Of	MP Criteria: Procedures/services reviewed against Medical		Moved from PA to
29877	Articular Cartilage (Chondroplasty)	Policy Criteria. Submit for Recommended Clinical Review to	1/1/2024	Recommended Clinical Review
	, , , , , , , , , , , , , , , , , , ,	avoid post-service review by Carelon.		01/01/2024
	Arthroscopy Knee Surgical; Abrasion Arthroplasty (Includes			Moved from PA to
29879	Chondroplasty Where Necessary) Or Multiple Drilling Or	Policy Criteria. Submit for Recommended Clinical Review to	1/1/2024	Recommended Clinical Review
	Microfracture	avoid post-service review by Carelon.		01/01/2024
	Arthroscopy Knee Surgical; With Meniscectomy (Medial			
	And Lateral Including Any Meniscal Shaving) Including	MP Criteria: Procedures/services reviewed against Medical		
29880	Debridement/Shaving Of Articular Cartilage (Chondroplasty)	Policy Criteria. Submit for Recommended Clinical Review to	1/1/2024	Moved from PA to
	Same Or Separate Compartment(S) When Performed	avoid post-service review by Carelon.		Recommended Clinical Review
				01/01/2024
	Arthroscopy Knee Surgical; With Meniscectomy (Medial Or			
	Lateral Including Any Meniscal Shaving) Including	MP Criteria: Procedures/services reviewed against Medical		
29881	Debridement/Shaving Of Articular Cartilage (Chondroplasty)	Policy Criteria. Submit for Recommended Clinical Review to	1/1/2024	Moved from PA to
	Same Or Separate Compartment(S) When Performed	avoid post-service review by Carelon.		Recommended Clinical Review
				01/01/2024
	Arthroscopy Knee Surgical; With Meniscus Repair (Medial	MP Criteria: Procedures/services reviewed against Medical		Moved from PA to
29882	Or Lateral)	Policy Criteria. Submit for Recommended Clinical Review to	1/1/2024	_ Recommended Clinical Review
		avoid post-service review by Carelon.		01/01/2024
	Arthroscopy Knee Surgical; With Meniscus Repair (Medial	MP Criteria: Procedures/services reviewed against Medical		Moved from PA to
29883	And Lateral)	Policy Criteria. Submit for Recommended Clinical Review to	1/1/2024	Recommended Clinical Review
		avoid post-service review by Carelon.		01/01/2024
	Arthroscopy Knee Surgical; With Lysis Of Adhesions With	MP Criteria: Procedures/services reviewed against Medical		Moved from PA to
29884	Or Without Manipulation (Separate Procedure)	Policy Criteria. Submit for Recommended Clinical Review to	1/1/2024	Recommended Clinical Review
		avoid post-service review by Carelon.		01/01/2024
	Arthroscopy Knee Surgical; Drilling For Osteochondritis	MP Criteria: Procedures/services reviewed against Medical		Moved from PA to
29885	Dissecans With Bone Grafting With Or Without Internal	Policy Criteria. Submit for Recommended Clinical Review to	1/1/2024	Recommended Clinical Review
	Fixation (Including Debridement Of Base Of Lesion)	avoid post-service review by Carelon.		01/01/2024
	Arthroscopy Knee Surgical; Drilling For Intact	MP Criteria: Procedures/services reviewed against Medical		Moved from PA to
29886	Osteochondritis Dissecans Lesion	Policy Criteria. Submit for Recommended Clinical Review to	1/1/2024	Recommended Clinical Review
		avoid post-service review by Carelon.		01/01/2024
	Arthroscopy Knee Surgical; Drilling For Intact	MP Criteria: Procedures/services reviewed against Medical		Moved from PA to
29887	Osteochondritis Dissecans Lesion With Internal Fixation	Policy Criteria. Submit for Recommended Clinical Review to	1/1/2024	Recommended Clinical Review
		avoid post-service review by Carelon.		01/01/2024
	Arthroscopically Aided Anterior Cruciate Ligament	MP Criteria: Procedures/services reviewed against Medical	. /. /2.22 .	Moved from PA to
29888	Repair/Augmentation Or Reconstruction	Policy Criteria. Submit for Recommended Clinical Review to	1/1/2024	Recommended Clinical Review
		avoid post-service review by Carelon.		01/01/2024
2222	Arthroscopically Aided Posterior Cruciate Ligament	MP Criteria: Procedures/services reviewed against Medical	4 /4 /2024	Moved from PA to
29889	Repair/Augmentation Or Reconstruction	Policy Criteria. Submit for Recommended Clinical Review to	1/1/2024	Recommended Clinical Review
	A the constall Attack Books Of Leave Out - 1 - 1 - 1 - 1	avoid post-service review by Carelon.		01/01/2024
	Arthroscopically Aided Repair Of Large Osteochondritis	MP Criteria: Procedures/services reviewed against Medical		Moved from PA to
29892	Dissecans Lesion Talar Dome Fracture Or Tibial Plafond	Policy Criteria. Submit for Recommended Clinical Review to	1/1/2024	Recommended Clinical Review
	Fracture With Or Without Internal Fixation (Includes	avoid post-service review by Carelon.		
	Arthroscopy)			01/01/2024

	Arthroscopy Hip Surgical; With Femoroplasty (le	MP Criteria: Procedures/services reviewed against Medical			Moved from PA to
29914	Treatment Of Cam Lesion)	Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS.	-	_	Recommended Clinical Review 01/01/2024
29914	Arthroscopy Hip Surgical; With Femoroplasty (le Treatment Of Cam Lesion)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	-	-
29915	Arthroscopy Hip Surgical; With Acetabuloplasty (le Treatment Of Pincer Lesion)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS.	-	-	Moved from PA to Recommended Clinical Review 01/01/2024
29915	Arthroscopy Hip Surgical; With Acetabuloplasty (Ie Treatment Of Pincer Lesion)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	-	-	-
29916	Arthroscopy Hip Surgical; With Labral Repair	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS.	-	-	Moved from PA to Recommended Clinical Review 01/01/2024
29916	Arthroscopy Hip Surgical; With Labral Repair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	-	-	-
29999	Unlisted Procedure Arthroscopy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Unlisted or Undefined: Procedures/services not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-
30120	Excision Or Surgical Planing Of Skin Of Nose For Rhinophyma		-	-	-
30130	Excision Inferior Turbinate Partial Or Complete Any Method	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS.	-	-	-
30140	Submucous Resection Inferior Turbinate Partial Or Complete Any Method	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS.	-	_	-
30400	Rhinoplasty Primary; Lateral And Alar Cartilages And/Or Elevation Of Nasal Tip	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS.	_	_	_
30410	Rhinoplasty Primary; Complete External Parts Including Bony Pyramid Lateral And Alar Cartilages And/Or Elevation Of Nasal Tip	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS.	-	-	-
30420	Rhinoplasty Primary; Including Major Septal Repair	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS.	-	-	-

	Rhinoplasty Secondary; Minor Revision (Small Amount Of	MP Criteria: Procedures/services reviewed against Medical			
30430	Nasal Tip Work)	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by BCBS.			
	Rhinoplasty Secondary; Intermediate Revision (Bony Work	MP Criteria: Procedures/services reviewed against Medical			
30435	With Osteotomies)	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by BCBS.			
	Rhinoplasty Secondary; Major Revision (Nasal Tip Work And	MP Criteria: Procedures/services reviewed against Medical			
30450	Osteotomies)	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by BCBS.			
	Repair Of Nasal Valve Collapse With	EIU: Procedure/service not reimbursed by the Plan. Not			
30468	Subcutaneous/Submucosal Lateral Wall Implant(S)	subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Repair Of Nasal Valve Collapse With Low Energy	EIU: Procedure/service not reimbursed by the Plan. Not			
30469	Temperature-Controlled (le Radiofrequency)	subject to pre-service review. Check EIU policy, which is	_	_	_
	Subcutaneous/Submucosal Remodeling	one of our Clinical Payment and Coding Policy (CPCP).			
	Septoplasty Or Submucous Resection With Or Without	MP Criteria: Procedures/services reviewed against Medical			
30520	Cartilage Scoring Contouring Or Replacement With Graft	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by BCBS.			
	Unlisted Procedure Nose	Unlisted: Procedure/service not specifically defined or			
30999		classified, maybe subject to contract/clinical review. Prior			
30999		-	_	-	-
		Authorization may be required per contract agreement.			
	Nasal/Sinus Endoscopy Surgical; With Destruction By	EIU: Procedure/service not reimbursed by the Plan. Not			
31242	Radiofrequency Ablation Posterior Nasal Nerve	subject to pre-service review. Check EIU policy, which is		_	
		one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024		Add effective 05/15/2024
	Nasal/Sinus Endoscopy Surgical; With Destruction By	MP Criteria: Procedure/service reviewed against Medical			
31242	Radiofrequency Ablation Posterior Nasal Nerve	Policy Criteria. Submit for Recommended Clinical Review to			Add effective 02/15/2024
		avoid post-service review.	2/15/2024	5/14/2024	Retire effective 05/14/2024
	Nasal/Sinus Endoscopy Surgical; With Destruction By	EIU: Procedure/service not reimbursed by the Plan. Not			
31243	Cryoablation Posterior Nasal Nerve	subject to pre-service review. Check EIU policy, which is		_	
		one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024		Add effective 05/15/2024
	Nasal/Sinus Endoscopy Surgical; With Destruction By	MP Criteria: Procedure/service reviewed against Medical			
31243	Cryoablation Posterior Nasal Nerve	Policy Criteria. Submit for Recommended Clinical Review to			Add effective 02/15/2024
		avoid post-service review.	2/15/2024	5/14/2024	Retire effective 05/14/2024
	Nasal/Sinus Endoscopy Surgical With Dilation (Eg Balloon	MP Criteria: Procedures/services reviewed against Medical			
31296	Dilation); Frontal Sinus Ostium	Policy Criteria. Submit for Recommended Clinical Review to			
	"	avoid post-service review by BCBS.	_	_	_
	Nasal/Sinus Endoscopy Surgical With Dilation (Eg Balloon	MP Criteria: Procedures/services reviewed against Medical			
31297	Dilation); Sphenoid Sinus Ostium	Policy Criteria. Submit for Recommended Clinical Review to			
	<i>"</i>	avoid post-service review by BCBS.	_	_	_
	Unlisted Procedure Accessory Sinuses				
	,	Unlisted: Procedure/service not specifically defined or			
31299		classified, maybe subject to contract/clinical review. Prior	-	-	_
		Authorization may be required per contract agreement.			
	Unlisted Procedure Larynx	Unlisted: Procedure/service not specifically defined or			
31599	, , , , ,	classified, maybe subject to contract/clinical review.	-	-	_
		saddines, maybe subject to contracty clinical review.			

	Bronchoscopy Rigid Or Flexible Including Fluoroscopic	MP Criteria: Procedures/services reviewed against Medical			
31643	Guidance When Performed; With Placement Of Catheter(S)	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	For Intracavitary Radioelement Application	avoid post-service review by Carelon.			
31899	Unlisted Procedure Trachea Bronchi	Unlisted: Procedure/service not specifically defined or			
51099		classified, maybe subject to contract/clinical review.	_	-	-
	Thoracic Target(S) Delineation For Stereotactic Body	MP Criteria: Procedures/services reviewed against Medical			
32701	Radiation Therapy (Srs/Sbrt) (Photon Or Particle Beam)	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Entire Course Of Treatment	avoid post-service review by Carelon.			
	Lung Transplant Single; Without Cardiopulmonary Bypass	MP Criteria: Procedures/services reviewed against Medical			Moved from PA to
32851		Policy Criteria. Submit for Recommended Clinical Review to	_	_	Recommended Clinical Review
		avoid post-service review by BCBS.			9/18/2023
	Lung Transplant Single; With Cardiopulmonary Bypass	MP Criteria: Procedures/services reviewed against Medical			Moved from PA to
32852		Policy Criteria. Submit for Recommended Clinical Review to	_		Recommended Clinical Review
		avoid post-service review by BCBS.	_		9/18/2023
	Lung Transplant Double (Bilateral Sequential Or En Bloc);	MP Criteria: Procedures/services reviewed against Medical			Moved from PA to
32853	Without Cardiopulmonary Bypass	Policy Criteria. Submit for Recommended Clinical Review to			Recommended Clinical Review
	' ' ''	avoid post-service review by BCBS.	_		9/18/2023
	Lung Transplant Double (Bilateral Sequential Or En Bloc);	MP Criteria: Procedures/services reviewed against Medical			Moved from PA to
32854	With Cardiopulmonary Bypass	Policy Criteria. Submit for Recommended Clinical Review to			Recommended Clinical Review
	7 77 77 77 77 77 77 77 77 77 77 77 77 7	avoid post-service review by BCBS.	_	_	9/18/2023
	Ablation Therapy For Reduction Or Eradication Of 1 Or More				
	Pulmonary Tumor(S) Including Pleura Or Chest Wall When	MP Criteria: Procedure/service reviewed against Medical			
32994	Involved By Tumor Extension Percutaneous Including	Policy Criteria. Submit for Recommended Clinical Review to			
	Imaging Guidance When Performed Unilateral; Cryoablation	· ·	_	_	<u> </u>
	imaging dalatice when terrormed offiliateral, cryodolation	arola post ser nee remem			
	Ablation Therapy For Reduction Or Eradication Of 1 Or More				
	Pulmonary Tumor(S) Including Pleura Or Chest Wall When	MP Criteria: Procedure/service reviewed against Medical			
32998	Involved By Tumor Extension Percutaneous Including	Policy Criteria. Submit for Recommended Clinical Review to			
	Imaging Guidance When Performed Unilateral;	avoid post-service review.	_	_	-
	Radiofreguency	arola post ser nee renem			
	Unlisted Procedure Lungs And Pleura	Unlisted: Procedure/service not specifically defined or			
32999	omisted rioscaule zangs/maricana	classified, maybe subject to contract/clinical review.	_	_	_
	Insertion Or Replacement Of Temporary Transvenous Dual	MP Criteria: Procedure/service reviewed against Medical			
33211	Chamber Pacing Electrodes (Separate Procedure)	Policy Criteria. Submit for Recommended Clinical Review to			
55211	chamber racing electrodes (separate riocedure)	avoid post-service review.	_	_	-
	Exclusion Of Left Atrial Appendage Open Any Method (Eg	MP Criteria: Procedure/service reviewed against Medical			
33267	Excision Isolation Via Stapling Oversewing Ligation	Policy Criteria. Submit for Recommended Clinical Review to			
33207	Plication Clip)	avoid post-service review.	_	_	-
	Exclusion Of Left Atrial Appendage Open Performed At The	avoid post-service review.			
	Time Of Other Sternotomy Or Thoracotomy Procedure(S)	MP Criteria: Procedure/service reviewed against Medical			
33268	Any Method (Eg Excision Isolation Via Stapling Oversewing	•			
33200		avoid post-service review.	_	-	-
	Ligation Plication Clip) (List Separately In Addition To Code	avoiu post-service review.			
	For Primary Procedure) Exclusion Of Left Atrial Appendage Thoracoscopic Any	MP Criteria: Procedure/service reviewed against Medical			
33269		·			
33209	Method (Eg Excision Isolation Via Stapling Oversewing	Policy Criteria. Submit for Recommended Clinical Review to	_	-	-
	Ligation Plication Clip)	avoid post-service review.			

		I			
33274	Transcatheter Insertion Or Replacement Of Permanent Leadless Pacemaker Right Ventricular Including Imaging Guidance (Eg Fluoroscopy Venous Ultrasound Ventriculography Femoral Venography) And Device Evaluation (Eg Interrogation Or Programming) When Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	-	-	_
33275	Transcatheter Removal Of Permanent Leadless Pacemaker Right Ventricular Including Imaging Guidance (Eg Fluoroscopy Venous Ultrasound Ventriculography Femoral Venography) When Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	-	-	-
33276	Insertion Of Phrenic Nerve Stimulator System (Pulse Generator And Stimulating Lead[S]) Including Vessel Catheterization All Imaging Guidance And Pulse Generator Initial Analysis With Diagnostic Mode Activation When Performed	EIU: Procedure/service not 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	-	Add effective 05/15/2024
33276	Insertion Of Phrenic Nerve Stimulator System (Pulse Generator And Stimulating Lead[S]) Including Vessel Catheterization All Imaging Guidance And Pulse Generator Initial Analysis With Diagnostic Mode Activation When Performed	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	Insertion Of Phrenic Nerve Stimulator Transvenous Sensing Lead (List Separately In Addition To Code For Primary Procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	-	Add effective 05/15/2024
33277	Insertion Of Phrenic Nerve Stimulator Transvenous Sensing Lead (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	5/14/2024	Add effective 02/15/2024 Retire effective 05/14/2024
33278	Removal Of Phrenic Nerve Stimulator Including Vessel Catheterization All Imaging Guidance And Interrogation And Programming When Performed; System Including Pulse Generator And Lead(S)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	-	Add effective 05/15/2024
33278	Removal Of Phrenic Nerve Stimulator Including Vessel Catheterization All Imaging Guidance And Interrogation And Programming When Performed; System Including Pulse Generator And Lead(S)	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	Removal Of Phrenic Nerve Stimulator Including Vessel Catheterization All Imaging Guidance And Interrogation And Programming When Performed; Transvenous Stimulation Or Sensing Lead(S) 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	-	Add effective 05/15/2024
33279	Removal Of Phrenic Nerve Stimulator Including Vessel Catheterization All Imaging Guidance And Interrogation And Programming When Performed; Transvenous Stimulation Or Sensing Lead(S) 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
33280	Removal Of Phrenic Nerve Stimulator Including Vessel Catheterization All Imaging Guidance And Interrogation And Programming When Performed; Pulse Generator 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	-	Add effective 05/15/2024

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33280	Removal Of Phrenic Nerve Stimulator Including Vessel Catheterization All Imaging Guidance And Interrogation And Programming When Performed; Pulse Generator 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
33281	Repositioning Of Phrenic Nerve Stimulator Transvenous Lead(S)		5/15/2024	-	Add effective 05/15/2024
33281	Repositioning Of Phrenic Nerve Stimulator Transvenous Lead(S)	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
33285	Insertion Subcutaneous Cardiac Rhythm Monitor Including Programming	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	-	-	-
33287	Removal And Replacement Of Phrenic Nerve Stimulator Including Vessel Catheterization All Imaging Guidance And Interrogation And Programming When Performed; Pulse Generator	EIU: Procedure/service not 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	-	Add effective 05/15/2024
33287	Removal And Replacement Of Phrenic Nerve Stimulator Including Vessel Catheterization All Imaging Guidance And Interrogation And Programming When Performed; Pulse Generator	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	Removal And Replacement Of Phrenic Nerve Stimulator Including Vessel Catheterization All Imaging Guidance And Interrogation And Programming When Performed; Transvenous Stimulation Or Sensing Lead(S)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	-	Add effective 05/15/2024
33288	Removal And Replacement Of Phrenic Nerve Stimulator Including Vessel Catheterization All Imaging Guidance And Interrogation And Programming When Performed; Transvenous Stimulation Or Sensing Lead(S)	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
33289	Transcatheter Implantation Of Wireless Pulmonary Artery Pressure Sensor For Long-Term Hemodynamic Monitoring Including Deployment And Calibration Of The Sensor Right Heart Catheterization Selective Pulmonary Catheterization Radiological Supervision And Interpretation And Pulmonary Artery Angiography When Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	-	-	-
33418	Transcatheter Mitral Valve Repair Percutaneous Approach Including Transseptal Puncture When Performed; Initial Prosthesis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	-	-	-
33419	Transcatheter Mitral Valve Repair Percutaneous Approach Including Transseptal Puncture When Performed; Additional Prosthesis(Es) During Same Session (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	-	-	_
33542	Myocardial Resection (Eg Ventricular Aneurysmectomy)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	-	-	-

	Heart-Lung Transplant With Recipient Cardiectomy-	MP Criteria: Procedures/services reviewed against Medical		Moved from PA to
33935	Pneumonectomy	Policy Criteria. Submit for Recommended Clinical Review to		Recommended Clinical Review
	,	avoid post-service review by BCBS.	_	9/18/2023
	Heart Transplant With Or Without Recipient Cardiectomy	MP Criteria: Procedures/services reviewed against Medical		Moved from PA to
33945	,	Policy Criteria. Submit for Recommended Clinical Review to		Recommended Clinical Review
		avoid post-service review by BCBS.	_	9/18/2023
	Unlisted Procedure Cardiac Surgery	MP Criteria: Procedure/service reviewed against Medical		
		Policy Criteria. Submit for Recommended Clinical Review to		
		avoid post-service review.		
33999		Unlisted or Undefined: Procedures/services not specifically	_	-
		defined or classified, maybe subject to contract/clinical		
		review.		
	Unlisted Procedure Vascular Injection	Unlisted: Procedure/service not specifically defined or		
36299	omisted Procedure Vascalar Injection	classified, maybe subject to contract/clinical review.	_	_
	Injection Of Non-Compounded Foam Sclerosant With	classifica, maybe subject to contract, cliffical review.		
	Ultrasound Compression Maneuvers To Guide Dispersion Of	MP Criteria: Procedure/service reviewed against Medical		
36465	The Injectate Inclusive Of All Imaging Guidance And	Policy Criteria. Submit for Recommended Clinical Review to		
30403	,	avoid post-service review.	_	-
	Monitoring; Single Incompetent Extremity Truncal Vein (Eg	avoid post-service review.		
	Great Saphenous Vein Accessory Saphenous Vein) Injection Of Non-Compounded Foam Sclerosant With			
	· ·			
	Ultrasound Compression Maneuvers To Guide Dispersion Of	MP Criteria: Procedure/service reviewed against Medical		
36466	The Injectate Inclusive Of All Imaging Guidance And	Policy Criteria. Submit for Recommended Clinical Review to _	_	_
	Monitoring; Multiple Incompetent Truncal Veins (Eg Great	avoid post-service review.		
	Saphenous Vein Accessory Saphenous Vein) Same Leg			
	Injection(S) Of Sclerosant For Spider Veins (Telangiectasia)	MP Criteria: Procedure/service reviewed against Medical		
36468	Limb Or Trunk	Policy Criteria. Submit for Recommended Clinical Review to		
30408	Lillib Of Trulik	avoid post-service review.	_	-
	Injection Of Sclerosant; Single Incompetent Vein (Other	MP Criteria: Procedure/service reviewed against Medical		
36470	Than Telangiectasia)	Policy Criteria. Submit for Recommended Clinical Review to		
30470	Than Telanglectasia)	avoid post-service review.	-	-
	Injection Of Sclerosant; Multiple Incompetent Veins (Other	MP Criteria: Procedure/service reviewed against Medical		
36471	Than Telangiectasia) Same Leg	Policy Criteria. Submit for Recommended Clinical Review to		
30471	Than relangiectasia) same teg	avoid post-service review.	_	-
	Endovenous Ablation Therapy Of Incompetent Vein			
		EIU: Procedure/service not reimbursed by the Plan. Not		
36473	Extremity Inclusive Of All Imaging Guidance And Monitoring Percutaneous Mechanochemical; First Vein Treated	subject to pre-service review. Check EIU policy, which is	_	_
	Percutaneous Mechanochemical; First Vein Treated	one of our Clinical Payment and Coding Policy (CPCP).		
	Endovenous Ablation Therapy Of Incompetent Vein			
	Extremity Inclusive Of All Imaging Guidance And Monitoring			
	Extremity Inclusive Of All Imaging Guidance And Monitoring	EIU: Procedure/service not reimbursed by the Plan. Not		
36474	rereatanced wicenament, subsequent veni(s)	subject to pre-service review. Check EIU policy, which is	_	_
	Treated In A Single Extremity Each Through Separate Access	one of our Clinical Payment and Coding Policy (CPCP).		
	Sites (List Separately In Addition To Code For Primary			
	Procedure)			

36475	Endovenous Ablation Therapy Of Incompetent Vein Extremity Inclusive Of All Imaging Guidance And Monitoring Percutaneous Radiofrequency; First Vein Treated	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	-	-	-
36476	Endovenous Ablation Therapy Of Incompetent Vein Extremity Inclusive Of All Imaging Guidance And Monitoring Percutaneous Radiofrequency; Subsequent Vein(S) Treated In A Single Extremity Each Through Separate Access Sites (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	-	-	-
36478	Endovenous Ablation Therapy Of Incompetent Vein Extremity Inclusive Of All Imaging Guidance And Monitoring Percutaneous Laser; First Vein Treated	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	-	-	-
36479	Endovenous Ablation Therapy Of Incompetent Vein Extremity Inclusive Of All Imaging Guidance And Monitoring Percutaneous Laser; Subsequent Vein(S) Treated In A Single Extremity Each Through Separate Access Sites (List Separately In Addition To Code For Primary Procedure)	INDECTIFICATION PROCESSING PROCESSING INTERIOR I	-	-	_
36482	Endovenous Ablation Therapy Of Incompetent Vein Extremity By Transcatheter Delivery Of A Chemical Adhesive (Eg Cyanoacrylate) Remote From The Access Site Inclusive Of All Imaging Guidance And Monitoring Percutaneous; First Vein Treated	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	-	-	-
36483	Endovenous Ablation Therapy Of Incompetent Vein Extremity By Transcatheter Delivery Of A Chemical Adhesive (Eg Cyanoacrylate) Remote From The Access Site Inclusive Of All Imaging Guidance And Monitoring Percutaneous; Subsequent Vein(S) Treated In A Single Extremity Each Through Separate Access Sites (List Separately In Addition To	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	-	-	_
36516	Therapeutic Apheresis; With Extracorporeal Immunoadsorption Selective Adsorption Or Selective Filtration And Plasma Reinfusion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	-	-	-
36522	Photopheresis Extracorporeal	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	-	-	-
36836	Percutaneous Arteriovenous Fistula Creation Upper Extremity Single Access Of Both The Peripheral Artery And Peripheral Vein Including Fistula Maturation Procedures (Eg Transluminal Balloon Angioplasty Coil Embolization) When Performed Including All Vascular Access Imaging Guidance And Radiologic Supervision And Interpretation		-	-	-

	Percutaneous Arteriovenous Fistula Creation Upper				
	Extremity Separate Access Sites Of The Peripheral Artery				
	And Peripheral Vein Including Fistula Maturation	EIU: Procedure/service not reimbursed by the Plan. Not			
36837	Procedures (Eg Transluminal Balloon Angioplasty Coil	subject to pre-service review. Check EIU policy, which is			
	Embolization) When Performed Including All Vascular	one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
	Access Imaging Guidance And Radiologic Supervision And				
	Interpretation				
	Transcatheter Placement Of Intravascular Stent(S) Cervical				
	Carotid Artery Open Or Percutaneous Including Angioplasty	MP Criteria: Procedure/service reviewed against Medical			
37215	When Performed And Radiological Supervision And	Policy Criteria. Submit for Recommended Clinical Review to			
	Interpretation; With Distal Embolic Protection	avoid post-service review.	_	_	_
	interpretation, man platar Embone i roccoron				
	Transcatheter Placement Of Intravascular Stent(S) Cervical				
	Carotid Artery Open Or Percutaneous Including Angioplasty	MP Criteria: Procedure/service reviewed against Medical			
37216	When Performed And Radiological Supervision And	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Interpretation; Without Distal Embolic Protection	avoid post-service review.			
	Transcatheter Placement Of Intravascular Stent(S)				
	Intrathoracic Common Carotid Artery Or Innominate Artery				
	By Retrograde Treatment Open Ipsilateral Cervical Carotid	MP Criteria: Procedure/service reviewed against Medical			
37217	Artery Exposure Including Angioplasty When Performed	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	And Radiological Supervision And Interpretation	avoid post-service review.			
	And hadiological supervision and interpretation				
	Transcatheter Placement Of Intravascular Stent(S)				
	Intrathoracic Common Carotid Artery Or Innominate Artery	MP Criteria: Procedure/service reviewed against Medical			
37218	Open Or Percutaneous Antegrade Approach Including	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Angioplasty When Performed And Radiological Supervision	avoid post-service review.			
	And Interpretation				
	Vascular Embolization Or Occlusion Inclusive Of All				
	Radiological Supervision And Interpretation Intraprocedural				
27244	Roadmapping And Imaging Guidance Necessary To	MP Criteria: Procedure/service reviewed against Medical			
37241	Complete The Intervention; Venous Other Than	Policy Criteria. Submit for Recommended Clinical Review to	_	_	-
	Hemorrhage (Eg Congenital Or Acquired Venous	avoid post-service review.			
	Malformations Venous And Capillary Hemangiomas Varices				
	Varicoceles) Vascular Embolization Or Occlusion Inclusive Of All				
	Radiological Supervision And Interpretation Intraprocedural				
	Roadmapping And Imaging Guidance Necessary To	MP Criteria: Procedure/service reviewed against Medical			
37242	Complete The Intervention; Arterial Other Than	Policy Criteria. Submit for Recommended Clinical Review to			
- · - ·-	Hemorrhage Or Tumor (Eg. Congenital Or Acquired Arterial	avoid post-service review.	_	_	-
	Malformations Arteriovenous Malformations				
	Arteriovenous Fistulas Aneurysms Pseudoaneurysms)				
	Vascular Embolization Or Occlusion Inclusive Of All				
	Radiological Supervision And Interpretation Intraprocedural	MP Criteria: Procedure/service reviewed against Medical			
37243	Roadmapping And Imaging Guidance Necessary To	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Complete The Intervention; For Tumors Organ Ischemia Or	avoid post-service review.			
	Infarction				

	Vascular Embolization Or Occlusion Inclusive Of All				
37244	Radiological Supervision And Interpretation Intraprocedural	MP Criteria: Procedure/service reviewed against Medical			
		Policy Criteria. Submit for Recommended Clinical Review to			
	Roadmapping And Imaging Guidance Necessary To	·	_	-	-
	Complete The Intervention; For Arterial Or Venous	avoid post-service review.			
	Hemorrhage Or Lymphatic Extravasation	MP Criteria: Procedure/service reviewed against Medical			
37500	Vascular Endoscopy Surgical With Ligation Of Perforator	·			
	Veins Subfascial (Seps)	Policy Criteria. Submit for Recommended Clinical Review to	-	-	_
	W. F. J. W. J. 5 J. D. J.	avoid post-service review.			
37501	Unlisted Vascular Endoscopy Procedure	Unlisted: Procedure/service not specifically defined or			
		classified, maybe subject to contract/clinical review.	_	_	_
37700	Ligation And Division Of Long Saphenous Vein At	MP Criteria: Procedure/service reviewed against Medical			
	Saphenofemoral Junction Or Distal Interruptions	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
37718	Ligation Division And Stripping Short Saphenous Vein	MP Criteria: Procedure/service reviewed against Medical			
		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
37722	Ligation Division And Stripping Long (Greater) Saphenous	MP Criteria: Procedure/service reviewed against Medical			
	Veins From Saphenofemoral Junction To Knee Or Below	Policy Criteria. Submit for Recommended Clinical Review to		_	_
		avoid post-service review.			
37735	Ligation And Division And Complete Stripping Of Long Or	MP Criteria: Procedure/service reviewed against Medical			
	Short Saphenous Veins With Radical Excision Of Ulcer And	Policy Criteria. Submit for Recommended Clinical Review to			
	Skin Graft And/Or Interruption Of Communicating Veins Of	·	_	-	-
	Lower Leg With Excision Of Deep Fascia	avoid post-service review.			
37760	Ligation Of Perforator Veins Subfascial Radical (Linton Type)	MP Criteria: Procedure/service reviewed against Medical			
	Including Skin Graft When Performed Open 1 Leg	Policy Criteria. Submit for Recommended Clinical Review to	_		
		avoid post-service review.			
37761	Ligation Of Perforator Vein(S) Subfascial Open Including	MP Criteria: Procedure/service reviewed against Medical			
	Ultrasound Guidance When Performed 1 Leg	Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review.	_		
37765	Stab Phlebectomy Of Varicose Veins 1 Extremity; 10-20 Stab				
	Incisions	Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review.	_		_
37766	Stab Phlebectomy Of Varicose Veins 1 Extremity; More	MP Criteria: Procedure/service reviewed against Medical			
	Than 20 Incisions	Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review.	_	_	_
37780	Ligation And Division Of Short Saphenous Vein At	MP Criteria: Procedure/service reviewed against Medical			
	Saphenopopliteal Junction (Separate Procedure)	Policy Criteria. Submit for Recommended Clinical Review to			
	Supricinopophical surface (Separate Frocedure)	avoid post-service review.	_	_	-
37785	Ligation Division And/Or Excision Of Varicose Vein	MP Criteria: Procedure/service reviewed against Medical			
	Cluster(S) 1 Leg	Policy Criteria. Submit for Recommended Clinical Review to			
	Cluster(5) 1 Leg	avoid post-service review.	-	-	_
37799	Unlisted Procedure Vascular Surgery	Unlisted: Procedure/service not specifically defined or			
	Offisied Frocedure Vascular Surgery	classified, maybe subject to contract/clinical review.	_	_	_
	Unlisted Laparoscopy Procedure Spleen	Unlisted: Procedure/service not specifically defined or			
38129	offisted Laparoscopy Frotedure Spieeri		_	_	_
		classified, maybe subject to contract/clinical review.			

	Management Of Recipient Hematopoietic Progenitor Cell	MP Criteria: Procedure/service reviewed against Medical		
38204	Donor Search And Cell Acquisition	Policy Criteria. Submit for Recommended Clinical Review to		
	Solioi Sociioi i ilia Soli i ioquisioi:	avoid post-service review.	-	
	Blood-Derived Hematopoietic Progenitor Cell Harvesting For	MP Criteria: Procedure/service reviewed against Medical		
38205	Transplantation Per Collection; Allogeneic	Policy Criteria. Submit for Recommended Clinical Review to _		
		avoid post-service review.		
	Blood-Derived Hematopoietic Progenitor Cell Harvesting For	MP Criteria: Procedure/service reviewed against Medical		
38206	Transplantation Per Collection; Autologous	Policy Criteria. Submit for Recommended Clinical Review to		
36200		avoid post-service review. Prior Authorization may be		
		required per contract agreement.		
	Transplant Preparation Of Hematopoietic Progenitor Cells;	MP Criteria: Procedure/service reviewed against Medical		
38207	Cryopreservation And Storage	Policy Criteria. Submit for Recommended Clinical Review to _		
		avoid post-service review.		
	Transplant Preparation Of Hematopoietic Progenitor Cells;	MP Criteria: Procedure/service reviewed against Medical		
38208	Thawing Of Previously Frozen Harvest Without Washing	Policy Criteria. Submit for Recommended Clinical Review to		
	Per Donor	avoid post-service review.		
	Transplant Preparation Of Hematopoietic Progenitor Cells;	MP Criteria: Procedure/service reviewed against Medical		
38209	Thawing Of Previously Frozen Harvest With Washing Per	Policy Criteria. Submit for Recommended Clinical Review to	-	
	Donor Transplant Presenting Of Hemotographic Presenting College	avoid post-service review.		
20240	Transplant Preparation Of Hematopoietic Progenitor Cells;	MP Criteria: Procedure/service reviewed against Medical		
38210	Specific Cell Depletion Within Harvest T-Cell Depletion	Policy Criteria. Submit for Recommended Clinical Review to	-	
	Transplant Preparation Of Hematopoietic Progenitor Cells;	avoid post-service review. MP Criteria: Procedure/service reviewed against Medical		
38211	Tumor Cell Depletion	Policy Criteria. Submit for Recommended Clinical Review to		
30211	Tullior Cell Depletion	avoid post-service review.	-	
	Transplant Preparation Of Hematopoietic Progenitor Cells;	MP Criteria: Procedure/service reviewed against Medical		
38212	Red Blood Cell Removal	Policy Criteria. Submit for Recommended Clinical Review to		
55212	ned blood cen nemoval	avoid post-service review.	-	
	Transplant Preparation Of Hematopoietic Progenitor Cells;	MP Criteria: Procedure/service reviewed against Medical		
38213	Platelet Depletion	Policy Criteria. Submit for Recommended Clinical Review to		
		avoid post-service review.		
	Transplant Preparation Of Hematopoietic Progenitor Cells;	MP Criteria: Procedure/service reviewed against Medical		
38214	Plasma (Volume) Depletion	Policy Criteria. Submit for Recommended Clinical Review to _		
		avoid post-service review.		
	Transplant Preparation Of Hematopoietic Progenitor Cells;	MP Criteria: Procedure/service reviewed against Medical		
38215	Cell Concentration In Plasma Mononuclear Or Buffy Coat	Policy Criteria. Submit for Recommended Clinical Review to _	_	
	Layer	avoid post-service review.		
	Bone Marrow Harvesting For Transplantation; Allogeneic	MP Criteria: Procedure/service reviewed against Medical		
38230		Policy Criteria. Submit for Recommended Clinical Review to		
30230		avoid post-service review. Prior Authorization may be	-	
		required per contract agreement.		
	Bone Marrow Harvesting For Transplantation; Autologous	MP Criteria: Procedure/service reviewed against Medical		
38232		Policy Criteria. Submit for Recommended Clinical Review to	-	
		avoid post-service review.		
	Hematopoietic Progenitor Cell (Hpc); Allogeneic	MP Criteria: Procedure/service reviewed against Medical		
38240	Transplantation Per Donor	Policy Criteria. Submit for Recommended Clinical Review to	-	
		avoid post-service review.		

	Hematopoietic Progenitor Cell (Hpc); Autologous	MP Criteria: Procedure/service reviewed against Medical			
38241	Transplantation	Policy Criteria. Submit for Recommended Clinical Review to			
30241		avoid post-service review. Prior Authorization may be	_	-	_
		required per contract agreement.			
	Allogeneic Lymphocyte Infusions	MP Criteria: Procedure/service reviewed against Medical			
38242		Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review.	_	_	-
	Hematopoietic Progenitor Cell (Hpc); Hpc Boost	MP Criteria: Procedure/service reviewed against Medical			
20242	Thematopoletic Progenitor Cell (Tipe), Tipe Boost	Policy Criteria. Submit for Recommended Clinical Review to			
38243		•	_	-	_
		avoid post-service review.			
	Lymphangiotomy Or Other Operations On Lymphatic	MP Criteria: Procedure/service reviewed against Medical			
38308	Channels	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
20500	Unlisted Laparoscopy Procedure Lymphatic System	Unlisted: Procedure/service not specifically defined or			
38589		classified, maybe subject to contract/clinical review.	_	-	_
	Unlisted Procedure Hemic Or Lymphatic System	Unlisted: Procedure/service not specifically defined or			
38999		classified, maybe subject to contract/clinical review.	_	_	_
	Unlisted Procedure Mediastinum	Unlisted: Procedure/service not specifically defined or			
39499	Offisted Procedure Wediastiffulfi	· · · · · · · · · · · · · · · · · · ·	_	_	_
		classified, maybe subject to contract/clinical review.			
39599	Unlisted Procedure 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			
40733		classified, maybe subject to contract/clinical review.	_	-	_
40000	Unlisted Procedure Vestibule Of Mouth	Unlisted: Procedure/service not specifically defined or			
40899		classified, maybe subject to contract/clinical review.	_	_	_
	Placement Of Needles Catheters Or Other Device(S) Into				
	The Head And/Or Neck Region (Percutaneous Transoral Or	MP Criteria: Procedures/services reviewed against Medical			
41019	Transnasal) For Subsequent Interstitial Radioelement	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	· ·	avoid post-service review by Carelon.			
	Application	FILL Durandous / samina and universely world by the Dlag Net			
	Submucosal Ablation Of The Tongue Base Radiofrequency 1				
41530	Or More Sites Per Session	subject to pre-service review. Check EIU policy, which is	_		
		one of our Clinical Payment and Coding Policy (CPCP).		3/31/2024	Retire effective 03/31/2024
	Submucosal Ablation Of The Tongue Base Radiofrequency 1	MP Criteria: Procedure/service reviewed against Medical			
41530	Or More Sites Per Session	Policy Criteria. Submit for Recommended Clinical Review to		_	
		avoid post-service review.	4/1/2024		Add effective 04/01/2024
	Unlisted Procedure Tongue Floor Of Mouth	Unlisted: Procedure/service not specifically defined or			
41599	ĭ	classified, maybe subject to contract/clinical review.	_	_	_
	Gingivectomy Excision Gingiva Each Quadrant	Non Covered: Procedure/service not covered by the Plan.			
41820	dingivectority Excision dingiva Each Quadrant	•	_	_	_
	On availanta var. Funisian Baris	Not subject to pre-service review.			
41821	Operculectomy Excision Pericoronal Tissues	Non Covered: Procedure/service not covered by the Plan.			
		Not subject to pre-service review.	_	_	
41822	Excision Of Fibrous Tuberosities Dentoalveolar Structures	Non Covered: Procedure/service not covered by the Plan.			
71022		Not subject to pre-service review.	-	-	_
44022	Excision Of Osseous Tuberosities Dentoalveolar Structures	Non Covered: Procedure/service not covered by the Plan.			
41823		Not subject to pre-service review.	_	-	-
	Excision Of Hyperplastic Alveolar Mucosa Each Quadrant	Non Covered: Procedure/service not covered by the Plan.			
41828		·	_	_	_
	(Specify)	Not subject to pre-service review.			

	Alveolectomy Including Curettage Of Osteitis Or	Non Covered: Procedure/service not covered by the Plan.			
41830	Sequestrectomy	Not subject to pre-service review.	-	-	_
	Periodontal Mucosal Grafting	Non Covered: Procedure/service not covered by the Plan.			
41870	_	Not subject to pre-service review.	_	-	_
44.072	Gingivoplasty Each Quadrant (Specify)	Non Covered: Procedure/service not covered by the Plan.			
41872		Not subject to pre-service review.	-	-	-
41074	Alveoloplasty Each Quadrant (Specify)	Non Covered: Procedure/service not covered by the Plan.			
41874		Not subject to pre-service review.	-	_	_
41000	Unlisted Procedure Dentoalveolar Structures	Unlisted: Procedure/service not specifically defined or			
41899		classified, maybe subject to contract/clinical review.	-	-	-
	Uvulectomy Excision Of Uvula	MP Criteria: Procedure/service reviewed against Medical			
42140		Policy Criteria. Submit for Recommended Clinical Review to		_	
		avoid post-service review.	4/1/2024		Add effective 04/01/2024
	Palatopharyngoplasty (Eg Uvulopalatopharyngoplasty	MP Criteria: Procedure/service reviewed against Medical			
42145	Uvulopharyngoplasty)	Policy Criteria. Submit for Recommended Clinical Review to		_	
		avoid post-service review.	4/1/2024		Add effective 04/01/2024
42299	Unlisted Procedure Palate Uvula	Unlisted: Procedure/service not specifically defined or			
42299		classified, maybe subject to contract/clinical review.	-	-	_
42000	Unlisted Procedure Salivary Glands Or Ducts	Unlisted: Procedure/service not specifically defined or			
42699		classified, maybe subject to contract/clinical review.	-	-	-
	Pharyngoplasty (Plastic Or Reconstructive Operation On	MP Criteria: Procedure/service reviewed against Medical			
42950	Pharynx)	Policy Criteria. Submit for Recommended Clinical Review to		_	
		avoid post-service review.	4/1/2024		Add effective 04/01/2024
42000	Unlisted Procedure Pharynx Adenoids Or Tonsils	Unlisted: Procedure/service not specifically defined or			
42999		classified, maybe subject to contract/clinical review.	-	_	_
	Esophagoscopy Flexible Transoral; With Optical	EIU: Procedure/service not reimbursed by the Plan. Not			
43206	Endomicroscopy	subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Esophagogastroduodenoscopy Flexible Transoral; With	MP Criteria: Procedure/service reviewed against Medical			
43236	Directed Submucosal Injection(S) Any Substance	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Esophagogastroduodenoscopy Flexible Transoral; With	EIU: Procedure/service not reimbursed by the Plan. Not			
43252	Optical Endomicroscopy	subject to pre-service review. Check EIU policy, which is			_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Laparoscopy Surgical Esophageal Sphincter Augmentation	NAD Cuitaria. Durandura / namina na incurad ancient Nacidial			
42204	Procedure Placement Of Sphincter Augmentation Device (le	MP Criteria: Procedure/service reviewed against Medical			
43284	Magnetic Band) Including Cruroplasty When Performed	Policy Criteria. Submit for Recommended Clinical Review to	_	-	-
		avoid post-service review.			
42222	Unlisted Laparoscopy Procedure Esophagus	Unlisted: Procedure/service not specifically defined or			
43289		classified, maybe subject to contract/clinical review.	_	_	_
	Esophagogastroduodenoscopy Flexible Transoral; With	EIU: Procedure/service not reimbursed by the Plan. Not			
43290	Deployment Of Intragastric Bariatric Balloon	subject to pre-service review. Check EIU policy, which is			
	,	one of our Clinical Payment and Coding Policy (CPCP).	_		
	Esophagogastroduodenoscopy Flexible Transoral; With	EIU: Procedure/service not reimbursed by the Plan. Not			
43291	Removal Of Intragastric Bariatric Balloon(S)	subject to pre-service review. Check EIU policy, which is			
	200000000000000000000000000000000000000	one of our Clinical Payment and Coding Policy (CPCP).	_	_	
		The state of the s			

	Unlisted Procedure Esophagus	Unlisted: Procedure/service not specifically defined or			
43499	Offisted Procedure Esophagus	classified, maybe subject to contract/clinical review.	_	_	_
	Gastrectomy Partial Distal; With Gastrojejunostomy	MP Criteria: Procedure/service reviewed against Medical			
43632	Gustrectomy Furtial Distal, With Gustrojejunostomy	Policy Criteria. Submit for Recommended Clinical Review to			
43032		avoid post-service review.	_	-	-
	Gastrectomy Partial Distal; With Roux-En-Y Reconstruction	MP Criteria: Procedure/service reviewed against Medical			
43633	Gastrectomy Fartial Distal, With Noux-En-T Neconstruction	Policy Criteria. Submit for Recommended Clinical Review to			
43033		avoid post-service review.	_	-	-
	Laparoscopy Surgical Gastric Restrictive Procedure; With	MP Criteria: Procedure/service reviewed against Medical			
43644	Gastric Bypass And Roux-En-Y Gastroenterostomy (Roux	Policy Criteria. Submit for Recommended Clinical Review to			
43044	Limb 150 Cm Or Less)	avoid post-service review.	_	-	-
	Laparoscopy Surgical Gastric Restrictive Procedure; With	MP Criteria: Procedure/service reviewed against Medical			
43645	Gastric Bypass And Small Intestine Reconstruction To Limit	Policy Criteria. Submit for Recommended Clinical Review to			
43043	• • • • • • • • • • • • • • • • • • • •	avoid post-service review.	_	-	-
	Absorption Laparoscopy Surgical; Implantation Or Replacement Of	MP Criteria: Procedures/services reviewed against Medical			
43647	Gastric Neurostimulator Electrodes Antrum	Policy Criteria. Submit for Recommended Clinical Review to			
43047	Gastric Neurostimulator Electrodes Antifuli	· ·	_	-	-
	Laparoscopy Surgical; Revision Or Removal Of Gastric	avoid post-service review by BCBS. MP Criteria: Procedures/services reviewed against Medical			
43648	· · · · · · · ·				
43048	Neurostimulator Electrodes Antrum	Policy Criteria. Submit for Recommended Clinical Review to	_	_	-
	Unlisted Lanarassany Dragodura Stamoch	avoid post-service review by BCBS. Unlisted: Procedure/service not specifically defined or			
43659	Unlisted Laparoscopy Procedure Stomach		_	_	_
	Lancacca Consider Contribution Department of Department of the Contribution Department of the	classified, maybe subject to contract/clinical review. MP Criteria: Procedure/service reviewed against Medical			
42770	Laparoscopy Surgical Gastric Restrictive Procedure;	·			
43770	Placement Of Adjustable Gastric Restrictive Device (Eg	Policy Criteria. Submit for Recommended Clinical Review to	_	-	-
	Gastric Band And Subcutaneous Port Components)	avoid post-service review. MP Criteria: Procedure/service reviewed against Medical			
42774	Laparoscopy Surgical Gastric Restrictive Procedure;	·			
43771		Policy Criteria. Submit for Recommended Clinical Review to	_	-	-
	Only	avoid post-service review.			
42772	Laparoscopy Surgical Gastric Restrictive Procedure;	MP Criteria: Procedure/service reviewed against Medical			
43772	Removal Of Adjustable Gastric Restrictive Device	Policy Criteria. Submit for Recommended Clinical Review to	_	-	-
	Component Only	avoid post-service review.			
40770	Laparoscopy Surgical Gastric Restrictive Procedure;	MP Criteria: Procedure/service reviewed against Medical			
43773	Removal And Replacement Of Adjustable Gastric Restrictive	Policy Criteria. Submit for Recommended Clinical Review to	_	_	-
	Device Component Only	avoid post-service review.			
40774	Laparoscopy Surgical Gastric Restrictive Procedure;	MP Criteria: Procedure/service reviewed against Medical			
43774	Removal Of Adjustable Gastric Restrictive Device And	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Subcutaneous Port Components	avoid post-service review.			
	Laparoscopy Surgical Gastric Restrictive Procedure;	MP Criteria: Procedure/service reviewed against Medical			
43775	Longitudinal Gastrectomy (le Sleeve Gastrectomy)	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Gastric Restrictive Procedure Without Gastric Bypass For	MP Criteria: Procedure/service reviewed against Medical			
43842	Morbid Obesity; Vertical-Banded Gastroplasty	Policy Criteria. Submit for Recommended Clinical Review to	_	-	_
		avoid post-service review.			
	**	_			
43843	Morbid Obesity; Other Than Vertical-Banded Gastroplasty	· ·	_	_	-
		avoid post-service review.			
43843	Gastric Restrictive Procedure Without Gastric Bypass For Morbid Obesity; Other Than Vertical-Banded Gastroplasty	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	-

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	Gastric Restrictive Procedure With Partial Gastrectomy	MP Criteria: Procedure/service reviewed against Medical			
43945	Pylorus-Preserving Duodenoileostomy And Ileoileostomy (50	Policy Criteria. Submit for Recommended Clinical Review to			
43845	To 100 Cm Common Channel) To Limit Absorption	•	_	-	_
	(Biliopancreatic Diversion With Duodenal Switch)	avoid post-service review.			
	Gastric Restrictive Procedure With Gastric Bypass For	MP Criteria: Procedure/service reviewed against Medical			
43846		Policy Criteria. Submit for Recommended Clinical Review to			
43640	Morbid Obesity; With Short Limb (150 Cm Or Less) Roux-En-	·	-	-	_
	Y Gastroenterostomy	avoid post-service review.			
	Gastric Restrictive Procedure With Gastric Bypass For	MP Criteria: Procedure/service reviewed against Medical			
43847	Morbid Obesity; With Small Intestine Reconstruction To	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Limit Absorption	avoid post-service review.			
	Revision Open Of Gastric Restrictive Procedure For Morbid	MP Criteria: Procedure/service reviewed against Medical			
43848	Obesity Other Than Adjustable Gastric Restrictive Device	Policy Criteria. Submit for Recommended Clinical Review to			
	(Separate Procedure)	avoid post-service review.	_	<u> </u>	-
	Implantation Or Replacement Of Gastric Neurostimulator	MP Criteria: Procedures/services reviewed against Medical		 	
42004	· ·				
43881	Electrodes Antrum Open	Policy Criteria. Submit for Recommended Clinical Review to	_	-	_
		avoid post-service review by BCBS.			
	Gastric Restrictive Procedure Open; Revision Of	MP Criteria: Procedure/service reviewed against Medical			
43886	Subcutaneous Port Component Only	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Gastric Restrictive Procedure Open; Removal Of	MP Criteria: Procedure/service reviewed against Medical			
43887	Subcutaneous Port Component Only	Policy Criteria. Submit for Recommended Clinical Review to			
13007	Subcutaneous Fort component only	avoid post-service review.	-	-	_
	Gastric Restrictive Procedure Open; Removal And	MP Criteria: Procedure/service reviewed against Medical			
12222		_			
43888	Replacement Of Subcutaneous Port Component Only	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
43999	Unlisted Procedure Stomach	Unlisted: Procedure/service not specifically defined or			
43333		classified, maybe subject to contract/clinical review.	-	-	_
	Intestinal Allotransplantation; From Cadaver Donor	MP Criteria: Procedures/services reviewed against Medical			Moved from PA to
44135		Policy Criteria. Submit for Recommended Clinical Review to			Recommended Clinical Review
		avoid post-service review by BCBS.	_	<u></u>	9/18/2023
	Intestinal Allotransplantation; From Living Donor	MP Criteria: Procedures/services reviewed against Medical			Moved from PA to
44136	intestinal Anothansplantation, from Living Donor	Policy Criteria. Submit for Recommended Clinical Review to			Recommended Clinical Review
44130		•	_	-	
		avoid post-service review by BCBS.			9/18/2023
44238	Unlisted Laparoscopy Procedure Intestine (Except Rectum)	Unlisted: Procedure/service not specifically defined or			
		classified, maybe subject to contract/clinical review.	_	_	_
44799	Unlisted Procedure Small Intestine	Unlisted: Procedure/service not specifically defined or			
44799		classified, maybe subject to contract/clinical review.	-	-	-
	Unlisted Procedure Meckel'S Diverticulum And The	Unlisted: Procedure/service not specifically defined or			
44899	Mesentery	classified, maybe subject to contract/clinical review.	_	_	_
	Unlisted Laparoscopy Procedure Appendix	Unlisted: Procedure/service not specifically defined or			
44979	Offisted Laparoscopy Procedure: Appendix	· · · · · · · · · · · · · · · · · · ·	_	_	_
		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	Unlisted Laparoscopy Procedure Rectum	Unlisted: Procedure/service not specifically defined or			
70733		classified, maybe subject to contract/clinical review.	-	-	-
45000	Unlisted Procedure Rectum	Unlisted: Procedure/service not specifically defined or			
45999		classified, maybe subject to contract/clinical review.	-	-	_

	Repair Of Anorectal Fistula With Plug (Eg Porcine Small	EIU: Procedure/service not reimbursed by the Plan. Not			
46707	Intestine Submucosa [Sis])	subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
46999	Unlisted Procedure Anus	Unlisted: Procedure/service not specifically defined or			
10333		classified, maybe subject to contract/clinical review.	_	-	_
	Liver Allotransplantation Orthotopic Partial Or Whole From	MP Criteria: Procedures/services reviewed against Medical			Moved from PA to
47135	Cadaver Or Living Donor Any Age	Policy Criteria. Submit for Recommended Clinical Review to	_	_	Recommended Clinical Review
		avoid post-service review by BCBS.			9/18/2023
	Laparoscopy Surgical Ablation Of 1 Or More Liver Tumor(S);	MP Criteria: Procedure/service reviewed against Medical			
47370	Radiofrequency	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
47270	Unlisted Laparoscopic Procedure Liver	Unlisted: Procedure/service not specifically defined or			
47379		classified, maybe subject to contract/clinical review.	-	-	-
	Ablation Open Of 1 Or More Liver Tumor(S);	MP Criteria: Procedure/service reviewed against Medical			
47380	Radiofrequency	Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review.			
	Ablation 1 Or More Liver Tumor(S) Percutaneous	MP Criteria: Procedure/service reviewed against Medical			
47382	Radiofrequency	Policy Criteria. Submit for Recommended Clinical Review to			
	' '	avoid post-service review.	_		_
	Unlisted Procedure Liver	Unlisted: Procedure/service not specifically defined or			
47399		classified, maybe subject to contract/clinical review.	_	-	-
	Unlisted Laparoscopy Procedure Biliary Tract	Unlisted: Procedure/service not specifically defined or			
47579	' ''	classified, maybe subject to contract/clinical review.	_	_	_
	Unlisted Procedure Biliary Tract	Unlisted: Procedure/service not specifically defined or			
47999	,	classified, maybe subject to contract/clinical review.	_	_	_
	Pancreatectomy Total Or Subtotal With Autologous	MP Criteria: Procedures/services reviewed against Medical			Moved from PA to
48160	Transplantation Of Pancreas Or Pancreatic Islet Cells	Policy Criteria. Submit for Recommended Clinical Review to			Recommended Clinical Review
1.220	Transplantation of Falls cas of Falls caste is let cons	avoid post-service review by BCBS.	_	_	9/18/2023
	Transplantation Of Pancreatic Allograft	MP Criteria: Procedures/services reviewed against Medical			Moved from PA to
48554		Policy Criteria. Submit for Recommended Clinical Review to			Recommended Clinical Review
		avoid post-service review by BCBS.	_	-	9/18/2023
	Unlisted Procedure Pancreas	Unlisted: Procedure/service not specifically defined or			7,-2,-22
48999	omisted i reseaure i and eas	classified, maybe subject to contract/clinical review.	_	_	_
	Unlisted Laparoscopy Procedure Abdomen Peritoneum And				
49329	Omentum	classified, maybe subject to contract/clinical review.	_	_	_
	Unlisted Laparoscopy Procedure Hernioplasty	Unlisted: Procedure/service not specifically defined or			
49659	Herniorrhaphy Herniotomy	classified, maybe subject to contract/clinical review.	_	_	_
	Unlisted Procedure Abdomen Peritoneum And Omentum	Unlisted: Procedure/service not specifically defined or			
49999	offisted Procedure Assorber Perionean And officiality	classified, maybe subject to contract/clinical review.	_	_	_
	Ablation Open 1 Or More Renal Mass Lesion(S)	MP Criteria: Procedure/service reviewed against Medical			
50250	Cryosurgical Including Intraoperative Ultrasound Guidance	Policy Criteria. Submit for Recommended Clinical Review to			
30230	, , ,	avoid post-service review.	_	-	-
	And Monitoring If Performed Renal Allotransplantation Implantation Of Graft; Without	MP Criteria: Procedure/service reviewed against Medical			
50360		Policy Criteria. Submit for Recommended Clinical Review to			
JU30U	Recipient Nephrectomy	avoid post-service review.	_	-	-
		avoiu post-service review.		1	<u> </u>

	Renal Allotransplantation Implantation Of Graft; With	MP Criteria: Procedures/services reviewed against Medical			Moved from PA to
50365	Recipient Nephrectomy	Policy Criteria. Submit for Recommended Clinical Review to			Recommended Clinical Review
	nediplem replinestorry	avoid post-service review by BCBS.	_	-	9/18/2023
	Renal autotransplantation, reimplantation of kidney	MP Criteria: Procedures/services reviewed against Medical			Moved from PA to
50380	nendi datoti displantation, reimplantation of kidney	Policy Criteria. Submit for Recommended Clinical Review to			Recommended Clinical Review
50500		avoid post-service review by BCBS.	-	-	9/18/2023
	Unlisted Laparoscopy Procedure Renal	Unlisted: Procedure/service not specifically defined or			3/10/2023
50549	Offisted Laparoscopy Procedure Renai	classified, maybe subject to contract/clinical review.	_	_	_
	Ablation 1 Or More Renal Tumor(S) Percutaneous	MP Criteria: Procedure/service reviewed against Medical			
50592	• •	Policy Criteria. Submit for Recommended Clinical Review to			
30392	Unilateral Radiofrequency	•	_	-	-
	Ablatian Banal Turnar(C) Hailataral Barantanaana	avoid post-service review. MP Criteria: Procedure/service reviewed against Medical			
50503	Ablation Renal Tumor(S) Unilateral Percutaneous				
50593	Cryotherapy	Policy Criteria. Submit for Recommended Clinical Review to	-	-	-
		avoid post-service review.			
50949	Unlisted Laparoscopy Procedure Ureter	Unlisted: Procedure/service not specifically defined or			
		classified, maybe subject to contract/clinical review.	_	-	_
	Endoscopic Injection Of Implant Material Into The	MP Criteria: Procedure/service reviewed against Medical			
51715	Submucosal Tissues Of The Urethra And/Or Bladder Neck	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
51999	Unlisted Laparoscopy Procedure Bladder	Unlisted: Procedure/service not specifically defined or			
31333		classified, maybe subject to contract/clinical review.	-	-	_
	Cystourethroscopy With Mechanical Urethral Dilation And				
52284	Urethral Therapeutic Drug Delivery By Drug-Coated Balloon	EIU: Procedure/service not reimbursed by the Plan. Not			
32204	Catheter For Urethral Stricture Or Stenosis Male Including	subject to pre-service review. Check EIU policy, which is		-	
	Fluoroscopy When Performed	one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024		Add effective 05/15/2024
	Cystourethroscopy With Mechanical Urethral Dilation And	MP Criteria: Procedure/service reviewed against Medical			
F2204	Urethral Therapeutic Drug Delivery By Drug-Coated Balloon	·			
52284	Catheter For Urethral Stricture Or Stenosis Male Including	Policy Criteria. Submit for Recommended Clinical Review to			Add effective 02/15/2024
	Fluoroscopy When Performed	avoid post-service review.	2/15/2024	5/14/2024	Retire effective 05/14/2024
	Cystourethroscopy (Including Ureteral Catheterization);	MP Criteria: Procedure/service reviewed against Medical			
52327	With Subureteric Injection Of Implant Material	Policy Criteria. Submit for Recommended Clinical Review to			
	, ,	avoid post-service review.			_
	Cystourethroscopy With Insertion Of Permanent Adjustable				
52441	Transprostatic Implant; Single Implant	Policy Criteria. Submit for Recommended Clinical Review to			
	The state of the s	avoid post-service review.	_	_	-
	Cystourethroscopy With Insertion Of Permanent Adjustable	· ·			
	Transprostatic Implant; Each Additional Permanent	MP Criteria: Procedure/service reviewed against Medical			
52442	Adjustable Transprostatic Implant (List Separately In	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Addition To Code For Primary Procedure)	avoid post-service review.			
	Insertion Of A Temporary Prostatic Urethral Stent Including	MP Criteria: Procedures/services reviewed against Medical			
53855	Urethral Measurement	Policy Criteria. Submit for Recommended Clinical Review to			
55055	oretinal weastrement	avoid post-service review by BCBS.	-	5/14/2024	Retire effective 05/14/2024
	Insertion Of A Temporary Prostatic Urethral Stent Including			5/ 14/ 2024	110 CHECUVE 03/ 14/ 2024
53855	Urethral Measurement	Policy Criteria. Submit for Recommended Clinical Review to			
22027	Orecinal Measurement	·	-	5/14/2024	Retire effective 05/14/2024
		avoid post-service review.		3/ 14/ 2024	Netire effective 03/14/2024

	Insertion Of A Temporary Prostatic Urethral Stent Including	EIU: Procedure/service not reimbursed by the Plan. Not			
53855	Urethral Measurement	subject to pre-service review. Check EIU policy, which is			
		one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	_	Add effective 05/15/2024
	Transurethral Radiofrequency Micro-Remodeling Of The	EIU: Procedure/service not reimbursed by the Plan. Not			
53860	Female Bladder Neck And Proximal Urethra For Stress	subject to pre-service review. Check EIU policy, which is			
	Urinary Incontinence	one of our Clinical Payment and Coding Policy (CPCP).	_		_
	Unlisted Procedure Urinary System	Unlisted: Procedure/service not specifically defined or			
53899	Omisted Frederic Omist, System	classified, maybe subject to contract/clinical review.	_	_	-
	Amputation Of Penis; Complete	MP Criteria: Procedure/service reviewed against Medical			
54125	/ impactation of Fema, complete	Policy Criteria. Submit for Recommended Clinical Review to			
5 . 1 2 5		avoid post-service review.	_	-	_
	Injection Procedure For Peyronie Disease;	MP Criteria: Procedure/service reviewed against Medical			
54200	injection roccuure roi regionie biseuse,	Policy Criteria. Submit for Recommended Clinical Review to			
34200		avoid post-service review.	-	-	_
	Injection Procedure For Peyronie Disease; With Surgical	MP Criteria: Procedure/service reviewed against Medical			
54205	Exposure Of Plaque	Policy Criteria. Submit for Recommended Clinical Review to			
34203	Exposure of Flaque	avoid post-service review.	-	-	-
	Injection Of Corpora Cavernosa With Pharmacologic	MP Criteria: Procedure/service reviewed against Medical			
54235		Policy Criteria. Submit for Recommended Clinical Review to			
54235	Agent(S) (Eg Papaverine Phentolamine)	•	_	-	-
	Inscrition Of Danila Practhesis, Non Inflatable (Comi Digid)	avoid post-service review. MP Criteria: Procedure/service reviewed against Medical			
F4400	Insertion Of Penile Prosthesis; Non-Inflatable (Semi-Rigid)				
54400		Policy Criteria. Submit for Recommended Clinical Review to	-	-	-
	Inscribed Of Deville Decembering Inflate ble (Calf Contained)	avoid post-service review. MP Criteria: Procedure/service reviewed against Medical			
54404	Insertion Of Penile Prosthesis; Inflatable (Self-Contained)	_			
54401		Policy Criteria. Submit for Recommended Clinical Review to	_	-	-
		avoid post-service review.			
54405	Insertion Of Multi-Component Inflatable Penile Prosthesis	MP Criteria: Procedure/service reviewed against Medical			
54405	Including Placement Of Pump Cylinders And Reservoir	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Insertion Of Testicular Prosthesis (Separate Procedure)	MP Criteria: Procedure/service reviewed against Medical			
54660		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
54699	Unlisted Laparoscopy Procedure Testis	Unlisted: Procedure/service not specifically defined or			
		classified, maybe subject to contract/clinical review.	_	_	_
55559	Unlisted Laparoscopy Procedure Spermatic Cord	Unlisted: Procedure/service not specifically defined or			
		classified, maybe subject to contract/clinical review.	-	-	_
	Exposure Of Prostate Any Approach For Insertion Of	MP Criteria: Procedures/services reviewed against Medical			
55860	Radioactive Substance;	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by Carelon.			
	Exposure Of Prostate Any Approach For Insertion Of	MP Criteria: Procedures/services reviewed against Medical			
55862	Radioactive Substance; With Lymph Node Biopsy(S) (Limited	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Pelvic Lymphadenectomy)	avoid post-service review by Carelon.			
	Exposure Of Prostate Any Approach For Insertion Of	MP Criteria: Procedures/services reviewed against Medical			
55865	Radioactive Substance; With Bilateral Pelvic	Policy Criteria. Submit for Recommended Clinical Review to			
55005	Lymphadenectomy Including External Iliac Hypogastric And	avoid post-service review by Carelon.	-	-	-
	Obturator Nodes	avoia post-service review by calcium.			

	Transperineal Placement Of Biodegradable Material Peri-	MP Criteria: Procedures/services reviewed against Medical			
55874	Prostatic Single Or Multiple Injection(S) Including Image	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Guidance When Performed	avoid post-service review by Carelon.			
	Transperineal Placement Of Needles Or Catheters Into	MP Criteria: Procedures/services reviewed against Medical			
55875	Prostate For Interstitial Radioelement Application With Or	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Without Cystoscopy	avoid post-service review by Carelon.			
	Ablation Of Malignant Prostate Tissue Transrectal With	MP Criteria: Procedure/service reviewed against Medical			
55880	High Intensity-Focused Ultrasound (Hifu) Including	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Ultrasound Guidance	avoid post-service review.			
	Unlisted Procedure Male Genital System	MP Criteria: Procedure/service reviewed against Medical			
		Policy Criteria. Submit for Recommended Clinical Review to			
FF800		avoid post-service review.			
55899		Unlisted or Undefined: Procedures/services not specifically	_	-	-
		defined or classified, maybe subject to contract/clinical			
		review.			
	Placement Of Needles Or Catheters Into Pelvic Organs	MP Criteria: Procedures/services reviewed against Medical			
55920	And/Or Genitalia (Except Prostate) For Subsequent	Policy Criteria. Submit for Recommended Clinical Review to	_		_
	Interstitial Radioelement Application	avoid post-service review by Carelon.			
	Intersex Surgery; Male To Female	MP Criteria: Procedure/service reviewed against Medical			
55970		Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review.	_		
	Intersex Surgery; Female To Male	MP Criteria: Procedure/service reviewed against Medical			
55980		Policy Criteria. Submit for Recommended Clinical Review to	_		_
		avoid post-service review.			
	Clitoroplasty For Intersex State	MP Criteria: Procedure/service reviewed against Medical			
56805		Policy Criteria. Submit for Recommended Clinical Review to	_		_
		avoid post-service review.			
	Perineoplasty Repair Of Perineum Nonobstetrical (Separate	MP Criteria: Procedure/service reviewed against Medical			
56810	Procedure)	Policy Criteria. Submit for Recommended Clinical Review to	_		_
		avoid post-service review.			
	Insertion Of Uterine Tandem And/Or Vaginal Ovoids For	MP Criteria: Procedures/services reviewed against Medical			
57155	Clinical Brachytherapy	Policy Criteria. Submit for Recommended Clinical Review to	_		_
	,	avoid post-service review by Carelon.			
	Insertion Of A Vaginal Radiation Afterloading Apparatus For	MP Criteria: Procedures/services reviewed against Medical			
57156	Clinical Brachytherapy	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	,	avoid post-service review by Carelon.			
	Construction Of Artificial Vagina; Without Graft	MP Criteria: Procedure/service reviewed against Medical			
57291		Policy Criteria. Submit for Recommended Clinical Review to	_		_
		avoid post-service review.			
	Construction Of Artificial Vagina; With Graft	MP Criteria: Procedure/service reviewed against Medical			
57292		Policy Criteria. Submit for Recommended Clinical Review to	_		_
		avoid post-service review.			
	Vaginoplasty For Intersex State	MP Criteria: Procedure/service reviewed against Medical			
57335		Policy Criteria. Submit for Recommended Clinical Review to	_		_
		avoid post-service review.			

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	Revision (Including Removal) Of Prosthetic Vaginal Graft	MP Criteria: Procedure/service reviewed against Medical			
57426	Laparoscopic Approach	Policy Criteria. Submit for Recommended Clinical Review to	_	-	_
		avoid post-service review.			
	Insertion Of Heyman Capsules For Clinical Brachytherapy	MP Criteria: Procedures/services reviewed against Medical			
58346		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by Carelon.			
50570	Unlisted Laparoscopy Procedure Uterus	Unlisted: Procedure/service not specifically defined or			
58578		classified, maybe subject to contract/clinical review.	_	-	-
	Unlisted Hysteroscopy Procedure Uterus	Unlisted: Procedure/service not specifically defined or			
58579	,	classified, maybe subject to contract/clinical review.	_	-	_
	Transcervical Ablation Of Uterine Fibroid(S) Including	MP Criteria: Procedure/service reviewed against Medical			
58580	Intraoperative Ultrasound Guidance And Monitoring	Policy Criteria. Submit for Recommended Clinical Review to			
36366	•	avoid post-service review.	2/15/2024	-	Add effective 02/15/2024
	Radiofrequency	Unlisted: Procedure/service not specifically defined or	2/13/2024		Aud effective 02/13/2024
58679	Unlisted Laparoscopy Procedure Oviduct Ovary		_	_	_
		classified, maybe subject to contract/clinical review.			
58999	Unlisted Procedure Female Genital System (Nonobstetrical)	Unlisted: Procedure/service not specifically defined or			
		classified, maybe subject to contract/clinical review.	_	_	-
	Fetal Umbilical Cord Occlusion Including Ultrasound	MP Criteria: Procedure/service reviewed against Medical			
59072	Guidance	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Fetal Fluid Drainage (Eg Vesicocentesis Thoracocentesis	MP Criteria: Procedure/service reviewed against Medical			
59074	Paracentesis) Including Ultrasound Guidance	Policy Criteria. Submit for Recommended Clinical Review to			_
	, °	avoid post-service review.			
	Fetal Shunt Placement Including Ultrasound Guidance	MP Criteria: Procedure/service reviewed against Medical			
59076		Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review.	_	_	-
	Unlisted Fetal Invasive Procedure Including Ultrasound	Unlisted: Procedure/service not specifically defined or			
59897	Guidance When Performed	classified, maybe subject to contract/clinical review.	_	_	_
	Unlisted Laparoscopy Procedure Maternity Care And	Unlisted: Procedure/service not specifically defined or			
59898	· · · · · · · · · · · · · · · · · · · ·	· · · · · · · · · · · · · · · · · · ·	_	_	_
	Delivery	classified, maybe subject to contract/clinical review.			
59899	Unlisted Procedure Maternity Care And Delivery	Unlisted: Procedure/service not specifically defined or			
		classified, maybe subject to contract/clinical review.	_	_	_
60659	Unlisted Laparoscopy Procedure Endocrine System	Unlisted: Procedure/service not specifically defined or			
00000		classified, maybe subject to contract/clinical review.	-	-	-
	Unlisted Procedure Endocrine System	MP Criteria: Procedure/service reviewed against Medical			
		Policy Criteria. Submit for Recommended Clinical Review to			
60699		avoid post-service review.			
60699		Unlisted or Undefined: Procedures/services not specifically	-	-	-
		defined or classified, maybe subject to contract/clinical			
		review.			
	Balloon Angioplasty Intracranial (Eg Atherosclerotic	EIU: Procedure/service not reimbursed by the Plan. Not			
61630	Stenosis) Percutaneous	subject to pre-service review. Check EIU policy, which is			
32330	Steriosis, i creaturicous	one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
	Transcatheter Placement Of Intravascular Stent(S)	MP Criteria: Procedure/service reviewed against Medical			
C1 C2 F	` ,	·			
61635	Intracranial (Eg. Atherosclerotic Stenosis) Including Balloon	Policy Criteria. Submit for Recommended Clinical Review to	-	-	-
	Angioplasty If Performed	avoid post-service review.			

61645	Percutaneous Arterial Transluminal Mechanical Thrombectomy And/Or Infusion For Thrombolysis Intracranial Any Method Including Diagnostic Angiography Fluoroscopic Guidance Catheter Placement And Intraprocedural Pharmacological Thrombolytic Injection(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2024	_	Add effective 02/1/2024
61650	Endovascular Intracranial Prolonged Administration Of Pharmacologic Agent(S) Other Than For Thrombolysis Arterial Including Catheter Placement Diagnostic Angiography And Imaging Guidance; Initial Vascular Territory	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	-	-	-
61651	Endovascular Intracranial Prolonged Administration Of Pharmacologic Agent(S) Other Than For Thrombolysis Arterial Including Catheter Placement Diagnostic Angiography And Imaging Guidance; Each Additional Vascular Territory (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	-	-	_
61783	Stereotactic Computer-Assisted (Navigational) Procedure; Spinal (List Separately In Addition To Code For Primary Procedure)		5/15/2024	6/30/2024	Add effective 05/15/2024 Retire effective 06/30/2024
61783	Stereotactic Computer-Assisted (Navigational) Procedure; Spinal (List Separately In Addition To Code For Primary Procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	-	Add effective 07/01/2024
61796	Stereotactic Radiosurgery (Particle Beam Gamma Ray Or Linear Accelerator); 1 Simple Cranial Lesion	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
61797	Stereotactic Radiosurgery (Particle Beam Gamma Ray Or Linear Accelerator); Each Additional Cranial Lesion Simple (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	-	-
61798	Stereotactic Radiosurgery (Particle Beam Gamma Ray Or Linear Accelerator); 1 Complex Cranial Lesion	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	_	_
61799	Stereotactic Radiosurgery (Particle Beam Gamma Ray Or Linear Accelerator); Each Additional Cranial Lesion Complex (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
61800	Application Of Stereotactic Headframe For Stereotactic Radiosurgery (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
61850	Twist Drill Or Burr Hole(S) For Implantation Of Neurostimulator Electrodes Cortical	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS.	-	-	-

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61863	Twist Drill Burr Hole Craniotomy Or Craniectomy With Stereotactic Implantation Of Neurostimulator Electrode Array In Subcortical Site (Eg Thalamus Globus Pallidus Subthalamic Nucleus Periventricular Periaqueductal Gray) Without Use Of Intraoperative Microelectrode Recording; First Array	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS.	-	-	-
61864	Twist Drill Burr Hole Craniotomy Or Craniectomy With Stereotactic Implantation Of Neurostimulator Electrode Array In Subcortical Site (Eg Thalamus Globus Pallidus Subthalamic Nucleus Periventricular Periaqueductal Gray) Without Use Of Intraoperative Microelectrode Recording; Each Additional Array (List Separately In Addition To Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS.	_	-	-
61867	Twist Drill Burr Hole Craniotomy Or Craniectomy With Stereotactic Implantation Of Neurostimulator Electrode Array In Subcortical Site (Eg Thalamus Globus Pallidus Subthalamic Nucleus Periventricular Periaqueductal Gray) With Use Of Intraoperative Microelectrode Recording; First Array	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS.	-	-	-
61868	Twist Drill Burr Hole Craniotomy Or Craniectomy With Stereotactic Implantation Of Neurostimulator Electrode Array In Subcortical Site (Eg Thalamus Globus Pallidus Subthalamic Nucleus Periventricular Periaqueductal Gray) With Use Of Intraoperative Microelectrode Recording; Each Additional Array (List Separately In Addition To Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS.	-	-	-
61889	Insertion Of Skull-Mounted Cranial Neurostimulator Pulse Generator Or Receiver Including Craniectomy Or Craniotomy When Performed With Direct Or Inductive Coupling With Connection To Depth And/Or Cortical Strip Electrode Array(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	-	Add effective 02/15/2024
61891	Revision Or Replacement Of Skull-Mounted Cranial Neurostimulator Pulse Generator Or Receiver With Connection To Depth And/Or Cortical Strip Electrode Array(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	-	Add effective 02/15/2024
61892	Removal Of Skull-Mounted Cranial Neurostimulator Pulse Generator Or Receiver With Cranioplasty When Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	-	Add effective 02/15/2024
62263	Percutaneous Lysis Of Epidural Adhesions Using Solution Injection (Eg Hypertonic Saline Enzyme) Or Mechanical Means (Eg Catheter) Including Radiologic Localization (Includes Contrast When Administered) Multiple Adhesiolysis Sessions; 2 Or More Days	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	-

	Percutaneous Lysis Of Epidural Adhesions Using Solution				
	Injection (Eg. Hypertonic Saline Enzyme) Or Mechanical	EIU: Procedure/service not reimbursed by the Plan. Not			
62264	Means (Eg. Catheter) Including Radiologic Localization	subject to pre-service review. Check EIU policy, which is			
0220 .	(Includes Contrast When Administered) Multiple	one of our Clinical Payment and Coding Policy (CPCP).	-	_	-
	Adhesiolysis Sessions; 1 Day	one or our chimear rayment and country to ney (er er).			
	Injection/Infusion Of Neurolytic Substance (Eg. Alcohol	MP Criteria: Procedures/services reviewed against Medical			
62280	Phenol Iced Saline Solutions) With Or Without Other	Policy Criteria. Submit for Recommended Clinical Review to			
	Therapeutic Substance; Subarachnoid	avoid post-service review by Carelon.	_	_	-
	Injection/Infusion Of Neurolytic Substance (Eg. Alcohol	MP Criteria: Procedures/services reviewed against Medical			
62281	Phenol Iced Saline Solutions) With Or Without Other	Policy Criteria. Submit for Recommended Clinical Review to			
	Therapeutic Substance; Epidural Cervical Or Thoracic	avoid post-service review by Carelon.	_	_	-
	Injection/Infusion Of Neurolytic Substance (Eg. Alcohol	MP Criteria: Procedures/services reviewed against Medical			
62282	Phenol Iced Saline Solutions) With Or Without Other	Policy Criteria. Submit for Recommended Clinical Review to			
	Therapeutic Substance; Epidural Lumbar Sacral (Caudal)	avoid post-service review by Carelon.	_	_	_
	Decompression Procedure Percutaneous Of Nucleus				
	Pulposus Of Intervertebral Disc Any Method Utilizing Needle				
	Based Technique To Remove Disc Material Under	EIU: Procedure/service not reimbursed by the Plan. Not			
62287	Fluoroscopic Imaging Or Other Form Of Indirect Visualization				
	With Discography And/Or Epidural Injection(S) At The	one of our Clinical Payment and Coding Policy (CPCP).	_		_
	Treated Level(S) When Performed Single Or Multiple Levels	, , , , ,			
	Lumbar				
	Injection Procedure For Chemonucleolysis Including	MP Criteria: Procedures/services reviewed against Medical			
62292	Discography Intervertebral Disc Single Or Multiple Levels	Policy Criteria. Submit for Recommended Clinical Review to			_
	Lumbar	avoid post-service review by Carelon.			
	Injection(S) Of Diagnostic Or Therapeutic Substance(S) (Eg				
	Anesthetic Antispasmodic Opioid Steroid Other Solution)	MP Criteria: Procedures/services reviewed against Medical			
62320	Not Including Neurolytic Substances Including Needle Or	Policy Criteria. Submit for Recommended Clinical Review to			
02320	Catheter Placement Interlaminar Epidural Or Subarachnoid	· ·	-	-	-
	Cervical Or Thoracic; Without Imaging Guidance	avoid post-service review by Carelon.			
	·				
	Injection(S) Of Diagnostic Or Therapeutic Substance(S) (Eg				
	Anesthetic Antispasmodic Opioid Steroid Other Solution)	MP Criteria: Procedures/services reviewed against Medical			
62321	Not Including Neurolytic Substances Including Needle Or	Policy Criteria. Submit for Recommended Clinical Review to			
02321	Catheter Placement Interlaminar Epidural Or Subarachnoid	•	-	-	-
	Cervical Or Thoracic; With Imaging Guidance (le	avoid post-service review by Carelon.			
	Fluoroscopy Or Ct)				
	Injection(S) Of Diagnostic Or Therapeutic Substance(S) (Eg				
	Anesthetic Antispasmodic Opioid Steroid Other Solution)	MP Criteria: Procedures/services reviewed against Medical			
62322	Not Including Neurolytic Substances Including Needle Or	Policy Criteria. Submit for Recommended Clinical Review to			
02322	Catheter Placement Interlaminar Epidural Or Subarachnoid	·	-	-	-
	Lumbar Or Sacral (Caudal); Without Imaging Guidance	avoid post-service review by Carelon.			

62323	Injection(S) Of Diagnostic Or Therapeutic Substance(S) (Eg Anesthetic Antispasmodic Opioid Steroid Other Solution) Not Including Neurolytic Substances Including Needle Or Catheter Placement Interlaminar Epidural Or Subarachnoid Lumbar Or Sacral (Caudal); With Imaging Guidance (Ie Fluoroscopy Or Ct)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	_	_
62325	Injection(S) Including Indwelling Catheter Placement Continuous Infusion Or Intermittent Bolus Of Diagnostic Or Therapeutic Substance(S) (Eg Anesthetic Antispasmodic Opioid Steroid Other Solution) Not Including Neurolytic Substances Interlaminar Epidural Or Subarachnoid Cervical Or Thoracic; With Imaging Guidance (Ie Fluoroscopy Or Ct)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_	_
62327	Injection(S) Including Indwelling Catheter Placement Continuous Infusion Or Intermittent Bolus Of Diagnostic Or Therapeutic Substance(S) (Eg Anesthetic Antispasmodic Opioid Steroid Other Solution) Not Including Neurolytic Substances Interlaminar Epidural Or Subarachnoid Lumbar Or Sacral (Caudal); With Imaging Guidance (Ie Fluoroscopy Or Ct)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
62350	Implantation Revision Or Repositioning Of Tunneled Intrathecal Or Epidural Catheter For Long-Term Medication Administration Via An External Pump Or Implantable Reservoir/Infusion Pump; Without Laminectomy	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
62351	Implantation Revision Or Repositioning Of Tunneled Intrathecal Or Epidural Catheter For Long-Term Medication Administration Via An External Pump Or Implantable Reservoir/Infusion Pump; With Laminectomy	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
62360	Implantation Or Replacement Of Device For Intrathecal Or Epidural Drug Infusion; Subcutaneous Reservoir	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
62361	Implantation Or Replacement Of Device For Intrathecal Or Epidural Drug Infusion; Nonprogrammable Pump	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
62362	Implantation Or Replacement Of Device For Intrathecal Or Epidural Drug Infusion; Programmable Pump Including Preparation Of Pump With Or Without Programming	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	-	-
62380	Endoscopic Decompression Of Spinal Cord Nerve Root(S) Including Laminotomy Partial Facetectomy Foraminotomy Discectomy And/Or Excision Of Herniated Intervertebral Disc 1 Interspace Lumbar	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
63001	Laminectomy With Exploration And/Or Decompression Of Spinal Cord And/Or Cauda Equina Without Facetectomy Foraminotomy Or Discectomy (Eg Spinal Stenosis) 1 Or 2 Vertebral Segments; Cervical	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-

63003	Laminectomy With Exploration And/Or Decompression Of Spinal Cord And/Or Cauda Equina Without Facetectomy Foraminotomy Or Discectomy (Eg Spinal Stenosis) 1 Or 2 Vertebral Segments; Thoracic	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
63005	Laminectomy With Exploration And/Or Decompression Of Spinal Cord And/Or Cauda Equina Without Facetectomy Foraminotomy Or Discectomy (Eg Spinal Stenosis) 1 Or 2 Vertebral Segments; Lumbar Except For Spondylolisthesis	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
63012	Laminectomy With Removal Of Abnormal Facets And/Or Pars Inter-Articularis With Decompression Of Cauda Equina And Nerve Roots For Spondylolisthesis Lumbar (Gill Type Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
63015	Laminectomy With Exploration And/Or Decompression Of Spinal Cord And/Or Cauda Equina Without Facetectomy Foraminotomy Or Discectomy (Eg Spinal Stenosis) More Than 2 Vertebral Segments; Cervical	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
63016	Laminectomy With Exploration And/Or Decompression Of Spinal Cord And/Or Cauda Equina Without Facetectomy Foraminotomy Or Discectomy (Eg Spinal Stenosis) More Than 2 Vertebral Segments; Thoracic	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
63017	Laminectomy With Exploration And/Or Decompression Of Spinal Cord And/Or Cauda Equina Without Facetectomy Foraminotomy Or Discectomy (Eg Spinal Stenosis) More Than 2 Vertebral Segments; Lumbar	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
63020	Laminotomy (Hemilaminectomy) With Decompression Of Nerve Root(S) Including Partial Facetectomy Foraminotomy And/Or Excision Of Herniated Intervertebral Disc; 1 Interspace Cervical	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
63030	Laminotomy (Hemilaminectomy) With Decompression Of Nerve Root(S) Including Partial Facetectomy Foraminotomy And/Or Excision Of Herniated Intervertebral Disc; 1 Interspace Lumbar	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
63035	Laminotomy (Hemilaminectomy) With Decompression Of Nerve Root(S) Including Partial Facetectomy Foraminotomy And/Or Excision Of Herniated Intervertebral Disc; Each Additional Interspace Cervical Or Lumbar (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
63040	Laminotomy (Hemilaminectomy) With Decompression Of Nerve Root(S) Including Partial Facetectomy Foraminotomy And/Or Excision Of Herniated Intervertebral Disc Reexploration Single Interspace; Cervical	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-

63042	Laminotomy (Hemilaminectomy) With Decompression Of Nerve Root(S) Including Partial Facetectomy Foraminotomy And/Or Excision Of Herniated Intervertebral Disc Reexploration Single Interspace; Lumbar	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
63043	Laminotomy (Hemilaminectomy) With Decompression Of Nerve Root(S) Including Partial Facetectomy Foraminotomy And/Or Excision Of Herniated Intervertebral Disc Reexploration Single Interspace; Each Additional Cervical Interspace (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
63044	Laminotomy (Hemilaminectomy) With Decompression Of Nerve Root(S) Including Partial Facetectomy Foraminotomy And/Or Excision Of Herniated Intervertebral Disc Reexploration Single Interspace; Each Additional Lumbar Interspace (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	_
63045	Laminectomy Facetectomy And Foraminotomy (Unilateral Or Bilateral With Decompression Of Spinal Cord Cauda Equina And/Or Nerve Root[S] [Eg Spinal Or Lateral Recess Stenosis]) Single Vertebral Segment; Cervical	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
63046	Laminectomy Facetectomy And Foraminotomy (Unilateral Or Bilateral With Decompression Of Spinal Cord Cauda Equina And/Or Nerve Root[S] [Eg Spinal Or Lateral Recess Stenosis]) Single Vertebral Segment; Thoracic	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	_	-
63047	Laminectomy Facetectomy And Foraminotomy (Unilateral Or Bilateral With Decompression Of Spinal Cord Cauda Equina And/Or Nerve Root[S] [Eg Spinal Or Lateral Recess Stenosis]) Single Vertebral Segment; Lumbar	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
63048	Laminectomy Facetectomy And Foraminotomy (Unilateral Or Bilateral With Decompression Of Spinal Cord Cauda Equina And/Or Nerve Root[S] [Eg Spinal Or Lateral Recess Stenosis]) Single Vertebral Segment; Each Additional Vertebral Segment Cervical Thoracic Or Lumbar (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	_	_
63050	Laminoplasty Cervical With Decompression Of The Spinal Cord 2 Or More Vertebral Segments;	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
63051	Laminoplasty Cervical With Decompression Of The Spinal Cord 2 Or More Vertebral Segments; With Reconstruction Of The Posterior Bony Elements (Including The Application Of Bridging Bone Graft And Non-Segmental Fixation Devices [Eg Wire Suture Mini-Plates] When Performed)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	_	_

63052	Laminectomy Facetectomy Or Foraminotomy (Unilateral Or Bilateral With Decompression Of Spinal Cord Cauda Equina And/Or Nerve Root[S] [Eg Spinal Or Lateral Recess Stenosis]) During Posterior Interbody Arthrodesis Lumbar; Single Vertebral Segment (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
63053	Laminectomy Facetectomy Or Foraminotomy (Unilateral Or Bilateral With Decompression Of Spinal Cord Cauda Equina And/Or Nerve Root[S] [Eg Spinal Or Lateral Recess Stenosis]) During Posterior Interbody Arthrodesis Lumbar; Each Additional Vertebral Segment (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
63055	Transpedicular Approach With Decompression Of Spinal Cord Equina And/Or Nerve Root(S) (Eg Herniated Intervertebral Disc) Single Segment; Thoracic	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	-	-
63056	Transpedicular Approach With Decompression Of Spinal Cord Equina And/Or Nerve Root(S) (Eg Herniated Intervertebral Disc) Single Segment; Lumbar (Including Transfacet Or Lateral Extraforaminal Approach) (Eg Far Lateral Herniated Intervertebral Disc)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	_	_
63057	Transpedicular Approach With Decompression Of Spinal Cord Equina And/Or Nerve Root(S) (Eg Herniated Intervertebral Disc) Single Segment; Each Additional Segment Thoracic Or Lumbar (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
63075	Discectomy Anterior With Decompression Of Spinal Cord And/Or Nerve Root(S) Including Osteophytectomy; Cervical Single Interspace	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
63076	Discectomy Anterior With Decompression Of Spinal Cord And/Or Nerve Root(S) Including Osteophytectomy; Cervical Each Additional Interspace (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
63081	Vertebral Corpectomy (Vertebral Body Resection) Partial Or Complete Anterior Approach With Decompression Of Spinal Cord And/Or Nerve Root(S); Cervical Single Segment	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
63082	Vertebral Corpectomy (Vertebral Body Resection) Partial Or Complete Anterior Approach With Decompression Of Spinal Cord And/Or Nerve Root(S); Cervical Each Additional Segment (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
63085	Vertebral Corpectomy (Vertebral Body Resection) Partial Or Complete Transthoracic Approach With Decompression Of Spinal Cord And/Or Nerve Root(S); Thoracic Single Segment	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-

	Vertebral Corpectomy (Vertebral Body Resection) Partial Or Complete Transthoracic Approach With Decompression Of	MP Criteria: Procedures/services reviewed against Medical			
63086	Spinal Cord And/Or Nerve Root(S); Thoracic Each Additional	Policy Criteria. Submit for Recommended Clinical Review to	_		
	Segment (List Separately In Addition To Code For Primary	avoid post-service review by Carelon.	_		
	Procedure)	, ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '			
	Vertebral Corpectomy (Vertebral Body Resection) Partial Or	MP Criteria: Procedures/services reviewed against Medical			
62097	Complete Combined Thoracolumbar Approach With	,			
63087	Decompression Of Spinal Cord Cauda Equina Or Nerve	Policy Criteria. Submit for Recommended Clinical Review to	_	_	-
	Root(S) Lower Thoracic Or Lumbar; Single Segment	avoid post-service review by Carelon.			
	Vertebral Corpectomy (Vertebral Body Resection) Partial Or				
	Complete Combined Thoracolumbar Approach With	MP Criteria: Procedures/services reviewed against Medical			
63088	Decompression Of Spinal Cord Cauda Equina Or Nerve	Policy Criteria. Submit for Recommended Clinical Review to			
03088	Root(S) Lower Thoracic Or Lumbar; Each Additional	avoid post-service review by Carelon.	_	-	-
	Segment (List Separately In Addition To Code For Primary	avoid post-service review by Carelon.			
	Procedure)				
	Vertebral Corpectomy (Vertebral Body Resection) Partial Or				
63090	Complete Transperitoneal Or Retroperitoneal Approach	MP Criteria: Procedures/services reviewed against Medical			
	With Decompression Of Spinal Cord Cauda Equina Or Nerve	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Root(S) Lower Thoracic Lumbar Or Sacral; Single Segment	avoid post-service review by Carelon.			
	Vertebral Corpectomy (Vertebral Body Resection) Partial Or	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to			
	Complete Transperitoneal Or Retroperitoneal Approach				
63091	With Decompression Of Spinal Cord Cauda Equina Or Nerve				
	Root(S) Lower Thoracic Lumbar Or Sacral; Each Additional		_	_	_
	Segment (List Separately In Addition To Code For Primary				
	Procedure)				
	Vertebral Corpectomy (Vertebral Body Resection) Partial Or				
	Complete Lateral Extracavitary Approach With	MP Criteria: Procedures/services reviewed against Medical			
63101	Decompression Of Spinal Cord And/Or Nerve Root(S) (Eg	Policy Criteria. Submit for Recommended Clinical Review to	_	-	_
	For Tumor Or Retropulsed Bone Fragments); Thoracic Single	avoid post-service review by Carelon.			
	Segment				
	Vertebral Corpectomy (Vertebral Body Resection) Partial Or	MD Culturian Durandouse (comition of the color of the col			
624.02	Complete Lateral Extracavitary Approach With	MP Criteria: Procedures/services reviewed against Medical			
63102	Decompression Of Spinal Cord And/Or Nerve Root(S) (Eg	Policy Criteria. Submit for Recommended Clinical Review to	_	-	-
	, , , , , , , , , , , , , , , , , , , ,	avoid post-service review by Carelon.			
	Segment Vertebral Cornectomy (Vertebral Redy Resection), Partial Or				
	Vertebral Corpectomy (Vertebral Body Resection) Partial Or				
	Complete Lateral Extracavitary Approach With	MP Criteria: Procedures/services reviewed against Medical			
63103	Decompression Of Spinal Cord And/Or Nerve Root(S) (Eg	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	For Tumor Or Retropulsed Bone Fragments); Thoracic Or	avoid post-service review by Carelon.			
	Lumbar Each Additional Segment (List Separately In				
	Addition To Code For Primary Procedure) Laminectomy With Rhizotomy; 1 Or 2 Segments	MP Criteria: Procedures/services reviewed against Medical		+	
63185	Laminectomy with Amzotomy, 1 of 2 segments	Policy Criteria. Submit for Recommended Clinical Review to			
03103		avoid post-service review by Carelon.	_	-	-
		avoid post-service review by Careion.			1

	Laminectomy With Rhizotomy; More Than 2 Segments	MP Criteria: Procedures/services reviewed against Medical			
63190		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by Carelon.			
	Laminectomy With Section Of Spinal Accessory Nerve	MP Criteria: Procedures/services reviewed against Medical			
63191		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by Carelon.			
	Laminectomy With Release Of Tethered Spinal Cord	MP Criteria: Procedures/services reviewed against Medical			
63200	Lumbar	Policy Criteria. Submit for Recommended Clinical Review to	_		
		avoid post-service review by Carelon.			
	Laminectomy For Excision Or Occlusion Of Arteriovenous	MP Criteria: Procedures/services reviewed against Medical			
63250	Malformation Of Spinal Cord; Cervical	Policy Criteria. Submit for Recommended Clinical Review to			
	, ,	avoid post-service review by Carelon.	_		_
	Laminectomy For Excision Or Occlusion Of Arteriovenous	MP Criteria: Procedures/services reviewed against Medical			
63252	Malformation Of Spinal Cord; Thoracolumbar	Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review by Carelon.	_	_	_
	Laminectomy For Excision Or Evacuation Of Intraspinal	MP Criteria: Procedures/services reviewed against Medical			
63265	Lesion Other Than Neoplasm Extradural; Cervical	Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review by Carelon.	_	-	_
	Laminectomy For Excision Or Evacuation Of Intraspinal	MP Criteria: Procedures/services reviewed against Medical			
63267	Lesion Other Than Neoplasm Extradural; Lumbar	Policy Criteria. Submit for Recommended Clinical Review to			
00207	Ecolori Otrici Mari reopiasiri Extradural, Edinisar	avoid post-service review by Carelon.	_	_	-
	Laminectomy For Excision Of Intraspinal Lesion Other Than	MP Criteria: Procedures/services reviewed against Medical			
63270	Neoplasm Intradural; Cervical	Policy Criteria. Submit for Recommended Clinical Review to			
03270	Neoplasiii ilitiadarai, eervicai	avoid post-service review by Carelon.	_	-	-
	Laminectomy For Excision Of Intraspinal Lesion Other Than	MP Criteria: Procedures/services reviewed against Medical			
63272	Neoplasm Intradural; Lumbar	Policy Criteria. Submit for Recommended Clinical Review to			
00272	Neoplasiii ilitiadarai, Edilisai	avoid post-service review by Carelon.	_	_	-
	Laminectomy For Biopsy/Excision Of Intraspinal Neoplasm;	MP Criteria: Procedures/services reviewed against Medical			
63275	Extradural Cervical	Policy Criteria. Submit for Recommended Clinical Review to			
00270	Extraduction Cervicus	avoid post-service review by Carelon.	_	_	-
	Laminectomy For Biopsy/Excision Of Intraspinal Neoplasm;	MP Criteria: Procedures/services reviewed against Medical			
63277	Extradural Lumbar	Policy Criteria. Submit for Recommended Clinical Review to			
03277	Extraudial Edition	avoid post-service review by Carelon.	_	-	_
	Laminectomy For Biopsy/Excision Of Intraspinal Neoplasm;	MP Criteria: Procedures/services reviewed against Medical			
63280	Intradural Extramedullary Cervical	Policy Criteria. Submit for Recommended Clinical Review to			
03200	intradurar Extramedulary Cervicar	avoid post-service review by Carelon.	_	-	-
	Laminectomy For Biopsy/Excision Of Intraspinal Neoplasm;	MP Criteria: Procedures/services reviewed against Medical			
63282	Intradural Extramedullary Lumbar	Policy Criteria. Submit for Recommended Clinical Review to			
03202	Intradurar Extramedunary Eurobar	avoid post-service review by Carelon.	_	-	-
	Laminectomy For Biopsy/Excision Of Intraspinal Neoplasm;	MP Criteria: Procedures/services reviewed against Medical		+	
63285	Intradural Intramedullary Cervical	Policy Criteria. Submit for Recommended Clinical Review to			
03283	intradural intramedulary cervical	·	_	-	-
	Laminoctomy For Bioncy/Excision Of Intrachinal Nearlasm	avoid post-service review by Carelon. MP Criteria: Procedures/services reviewed against Medical		+	
63287	Laminectomy For Biopsy/Excision Of Intraspinal Neoplasm;				
0328/	Intradural Intramedullary Thoracolumbar	Policy Criteria. Submit for Recommended Clinical Review to	_	-	-
	Laminactomy For Diancy/Fraisian Of Intercepted November	avoid post-service review by Carelon. MR Criteria: Procedures (carriese reviewed against Medical		+	
62200	Laminectomy For Biopsy/Excision Of Intraspinal Neoplasm;	MP Criteria: Procedures/services reviewed against Medical			
63290	Combined Extradural-Intradural Lesion Any Level	Policy Criteria. Submit for Recommended Clinical Review to	_	-	-
		avoid post-service review by Carelon.			

	Vertebral Corpectomy (Vertebral Body Resection) Partial Or	MP Criteria: Procedures/services reviewed against Medical			
C2200					
63300	Complete For Excision Of Intraspinal Lesion Single	Policy Criteria. Submit for Recommended Clinical Review to	-	-	-
	Segment; Extradural Cervical	avoid post-service review by Carelon.			
	Vertebral Corpectomy (Vertebral Body Resection) Partial Or				
63301	Complete For Excision Of Intraspinal Lesion Single	Policy Criteria. Submit for Recommended Clinical Review to	_	_	-
	Segment; Extradural Thoracic By Transthoracic Approach	avoid post-service review by Carelon.			
	Vertebral Corpectomy (Vertebral Body Resection) Partial Or	MP Criteria: Procedures/services reviewed against Medical			
63302	Complete For Excision Of Intraspinal Lesion Single	Policy Criteria. Submit for Recommended Clinical Review to			
	Segment; Extradural Thoracic By Thoracolumbar Approach	avoid post-service review by Carelon.	_	_	_
		arola post service remem sy careloni			
	Vertebral Corpectomy (Vertebral Body Resection) Partial Or	MP Criteria: Procedures/services reviewed against Medical			
63303	Complete For Excision Of Intraspinal Lesion Single	Policy Criteria. Submit for Recommended Clinical Review to			
	Segment; Extradural Lumbar Or Sacral By Transperitoneal	avoid post-service review by Carelon.	_	_	-
	Or Retroperitoneal Approach	· ·			
	Vertebral Corpectomy (Vertebral Body Resection) Partial Or	MP Criteria: Procedures/services reviewed against Medical			
63304	Complete For Excision Of Intraspinal Lesion Single	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Segment; Intradural Cervical	avoid post-service review by Carelon.			
	Vertebral Corpectomy (Vertebral Body Resection) Partial Or	MP Criteria: Procedures/services reviewed against Medical			
63305	Complete For Excision Of Intraspinal Lesion Single	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Segment; Intradural Thoracic By Transthoracic Approach	avoid post-service review by Carelon.			
	Vertebral Corpectomy (Vertebral Body Resection) Partial Or	MP Criteria: Procedures/services reviewed against Medical			
63306	Complete For Excision Of Intraspinal Lesion Single	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Segment; Intradural Thoracic By Thoracolumbar Approach	avoid post-service review by Carelon.			
	Vertebral Corpectomy (Vertebral Body Resection) Partial Or	MP Criteria: Procedures/services reviewed against Medical			
63307	Complete For Excision Of Intraspinal Lesion Single	Policy Criteria. Submit for Recommended Clinical Review to			
03307	Segment; Intradural Lumbar Or Sacral By Transperitoneal Or	avoid post-service review by Carelon.	_	-	-
	Retroperitoneal Approach	avoid post-service review by Careion.			
	Vertebral Corpectomy (Vertebral Body Resection) Partial Or	MP Criteria: Procedures/services reviewed against Medical			
63308	Complete For Excision Of Intraspinal Lesion Single	Policy Criteria. Submit for Recommended Clinical Review to			
05506	Segment; Each Additional Segment (List Separately In	·	-	_	-
	Addition To Codes For Single Segment)	avoid post-service review by Carelon.			
	Stereotactic Radiosurgery (Particle Beam Gamma Ray Or	MP Criteria: Procedures/services reviewed against Medical			
63620	Linear Accelerator); 1 Spinal Lesion	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by Carelon.			
	Stereotactic Radiosurgery (Particle Beam Gamma Ray Or	MP Criteria: Procedures/services reviewed against Medical			
63621	Linear Accelerator); Each Additional Spinal Lesion (List	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Separately In Addition To Code For Primary Procedure)	avoid post-service review by Carelon.			
	Percutaneous Implantation Of Neurostimulator Electrode	MP Criteria: Procedures/services reviewed against Medical			
63650	Array Epidural	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by Carelon.			
	Laminectomy For Implantation Of Neurostimulator	MP Criteria: Procedures/services reviewed against Medical			
63655	Electrodes Plate/Paddle Epidural	Policy Criteria. Submit for Recommended Clinical Review to	_		_
	· · ·	avoid post-service review by Carelon.			
	Revision Including Replacement When Performed Of Spinal	MP Criteria: Procedures/services reviewed against Medical			
63663	Neurostimulator Electrode Percutaneous Array(S) Including	Policy Criteria. Submit for Recommended Clinical Review to	_	L	_
	Fluoroscopy When Performed	avoid post-service review by Carelon.			
-	100	· · · · · · · · · · · · · · · · · · ·		•	•

	Revision Including Replacement When Performed Of Spinal	MP Criteria: Procedures/services reviewed against Medical			
63664	Neurostimulator Electrode Plate/Paddle(S) Placed Via	Policy Criteria. Submit for Recommended Clinical Review to			
03004	Laminotomy Or Laminectomy Including Fluoroscopy When	avoid post-service review by Carelon.	_	-	-
	Performed	avoid post service review by earcion.			
	Insertion Or Replacement Of Spinal Neurostimulator Pulse	MP Criteria: Procedures/services reviewed against Medical			
63685	Generator Or Receiver Requiring Pocket Creation And	Policy Criteria. Submit for Recommended Clinical Review to			
03003	Connection Between Electrode Array And Pulse Generator	avoid post-service review by Carelon.	_	-	-
	Or Receiver	· ·			
	Revision Or Removal Of Implanted Spinal Neurostimulator	MP Criteria: Procedures/services reviewed against Medical			
63688	Pulse Generator Or Receiver With Detachable Connection	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	To Electrode Array	avoid post-service review by Carelon.			
	Injection(S) Anesthetic Agent(S) And/Or Steroid; Nerves	MP Criteria: Procedures/services reviewed against Medical			
64451	Innervating The Sacroiliac Joint With Image Guidance (Ie	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Fluoroscopy Or Computed Tomography)	avoid post-service review by Carelon.			
	Injection(S) Anesthetic Agent(S) And/Or Steroid;	MP Criteria: Procedures/services reviewed against Medical			
64479	Transforaminal Epidural With Imaging Guidance	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	(Fluoroscopy Or Ct) Cervical Or Thoracic Single Level	avoid post-service review by Carelon.			
	Injection(S) Anesthetic Agent(S) And/Or Steroid;				
	Transforaminal Epidural With Imaging Guidance	MP Criteria: Procedures/services reviewed against Medical			
64480	(Fluoroscopy Or Ct) Cervical Or Thoracic Each Additional	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Level (List Separately In Addition To Code For Primary	avoid post-service review by Carelon.			
	Procedure)				
	Injection(S) Anesthetic Agent(S) And/Or Steroid;	MP Criteria: Procedures/services reviewed against Medical			
64483	Transforaminal Epidural With Imaging Guidance	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	(Fluoroscopy Or Ct) Lumbar Or Sacral Single Level	avoid post-service review by Carelon.			
	Injection(S) Anesthetic Agent(S) And/Or Steroid;				
	Transforaminal Epidural With Imaging Guidance	MP Criteria: Procedures/services reviewed against Medical			
64484	(Fluoroscopy Or Ct) Lumbar Or Sacral Each Additional Level	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	(List Separately In Addition To Code For Primary Procedure)	avoid post-service review by Carelon.			
	Injection(S) Diagnostic Or Therapeutic Agent Paravertebral	MP Criteria: Procedures/services reviewed against Medical			
64400	Facet (Zygapophyseal) Joint (Or Nerves Innervating That	Policy Criteria. Submit for Recommended Clinical Review to			
64490	Joint) With Image Guidance (Fluoroscopy Or Ct) Cervical Or	· ·	_	_	-
	Thoracic; Single Level	avoid post-service review by Carelon.			
	Injection(S) Diagnostic Or Therapeutic Agent Paravertebral				
	Facet (Zygapophyseal) Joint (Or Nerves Innervating That	MP Criteria: Procedures/services reviewed against Medical			
64491	Joint) With Image Guidance (Fluoroscopy Or Ct) Cervical Or	Policy Criteria. Submit for Recommended Clinical Review to	_		_
	Thoracic; Second Level (List Separately In Addition To Code	avoid post-service review by Carelon.			
	For Primary Procedure)				
	Injection(S) Diagnostic Or Therapeutic Agent Paravertebral				
	Facet (Zygapophyseal) Joint (Or Nerves Innervating That	NAD Critoria, Dragoduros (comisos rouisous da acticat NA discu			
64403	Joint) With Image Guidance (Fluoroscopy Or Ct) Cervical Or	MP Criteria: Procedures/services reviewed against Medical			
64492	Thoracic; Third And Any Additional Level(S) (List Separately	Policy Criteria. Submit for Recommended Clinical Review to	-	-	-
	In Addition To Code For Primary Procedure)	avoid post-service review by Carelon.			

	Injection(S) Diagnostic Or Therapeutic Agent Paravertebral	MP Criteria: Procedures/services reviewed against Medical			
64493	Facet (Zygapophyseal) Joint (Or Nerves Innervating That	Policy Criteria. Submit for Recommended Clinical Review to			
	Joint) With Image Guidance (Fluoroscopy Or Ct) Lumbar Or	avoid post-service review by Carelon.	_	_	-
	Sacral; Single Level	avoia post service review sy careform			
	Injection(S) Diagnostic Or Therapeutic Agent Paravertebral				
	Facet (Zygapophyseal) Joint (Or Nerves Innervating That	MP Criteria: Procedures/services reviewed against Medical			
64494	Joint) With Image Guidance (Fluoroscopy Or Ct) Lumbar Or	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Sacral; Second Level (List Separately In Addition To Code For	avoid post-service review by Carelon.			
	Primary Procedure)				
	Injection(S) Diagnostic Or Therapeutic Agent Paravertebral				
	Facet (Zygapophyseal) Joint (Or Nerves Innervating That	MP Criteria: Procedures/services reviewed against Medical			
64495	Joint) With Image Guidance (Fluoroscopy Or Ct) Lumbar Or	Policy Criteria. Submit for Recommended Clinical Review to			
04433	Sacral; Third And Any Additional Level(S) (List Separately In	avoid post-service review by Carelon.	_	-	_
	Addition To Code For Primary Procedure)	avoid post-service review by carelon.			
	Injection Anesthetic Agent; Stellate Ganglion (Cervical	MP Criteria: Procedures/services reviewed against Medical			
64510	Sympathetic)	Policy Criteria. Submit for Recommended Clinical Review to			
04310	Sympathetic)	avoid post-service review by Carelon.	_	-	_
	Injection Anesthetic Agent; Lumbar Or Thoracic	MP Criteria: Procedures/services reviewed against Medical			
64520	(Paravertebral Sympathetic)	Policy Criteria. Submit for Recommended Clinical Review to			
04320	(Faravertebrar Sympathetic)	avoid post-service review by Carelon.	-	-	_
	Percutaneous Implantation Of Neurostimulator Electrode	MP Criteria: Procedure/service reviewed against Medical			
64555	Array; Peripheral Nerve (Excludes Sacral Nerve)	Policy Criteria. Submit for Recommended Clinical Review to			
04333	Array, Peripheral Nerve (Excludes Sacral Nerve)	avoid post-service review.	_	-	-
	Percutaneous Implantation Of Neurostimulator Electrode	MP Criteria: Procedures/services reviewed against Medical			
64561	Array; Sacral Nerve (Transforaminal Placement) Including	Policy Criteria. Submit for Recommended Clinical Review to			
	Image Guidance If Performed	avoid post-service review by BCBS.	_	-	_
	Posterior Tibial Neurostimulation Percutaneous Needle	MP Criteria: Procedure/service reviewed against Medical			
64566	Electrode Single Treatment Includes Programming	Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review.	4/1/2024	_	Add effective 04/01/2024
	Open Implantation Of Cranial Nerve (Eg. Vagus Nerve)	MP Criteria: Procedure/service reviewed against Medical			
64568	Neurostimulator Electrode Array And Pulse Generator	Policy Criteria. Submit for Recommended Clinical Review to			
	, , , , , , , , , , , , , , , , , , , ,	avoid post-service review.	4/1/2024	_	Add effective 04/01/2024
	Open Implantation Of Neurostimulator Electrode Array;	MP Criteria: Procedure/service reviewed against Medical			
64575	Peripheral Nerve (Excludes Sacral Nerve)	Policy Criteria. Submit for Recommended Clinical Review to			
	, , , , , , , , , , , , , , , , , , ,	avoid post-service review.	_	_	_
	Open Implantation Of Neurostimulator Electrode Array;	MP Criteria: Procedures/services reviewed against Medical			
64581	Sacral Nerve (Transforaminal Placement)	Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review by BCBS.	_	_	_
	Open Implantation Of Hypoglossal Nerve Neurostimulator	MP Criteria: Procedure/service reviewed against Medical			
64503	Array Pulse Generator And Distal Respiratory Sensor	Policy Criteria. Submit for Recommended Clinical Review to			
64582	Electrode Or Electrode Array	avoid post-service review. Prior Authorization may be	_		
		required per contract agreement.		3/31/	2024 Retire effective 03/31/2024
	Insertion Or Replacement Of Peripheral Sacral Or Gastric				
64500	Neurostimulator Pulse Generator Or Receiver Requiring	MP Criteria: Procedure/service reviewed against Medical			
64590	Pocket Creation And Connection Between Electrode Array	Policy Criteria. Submit for Recommended Clinical Review to	_	_	-
	And Pulse Generator Or Receiver	avoid post-service review.			

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	Insertion Or Replacement Of Percutaneous Electrode Array	MP Criteria: Procedure/service reviewed against Medical			
64596	Peripheral Nerve With Integrated Neurostimulator	Policy Criteria. Submit for Recommended Clinical Review to			
0.000	Including Imaging Guidance When Performed; Initial	avoid nost sarvisa ravious		_	
	Electrode Array	avoid post service review.	2/15/2024		Add effective 02/15/2024
	Insertion Or Replacement Of Percutaneous Electrode Array				
	Peripheral Nerve With Integrated Neurostimulator	MP Criteria: Procedure/service reviewed against Medical			
64597	Including Imaging Guidance When Performed; Each	Policy Criteria. Submit for Recommended Clinical Review to		_	
	Additional Electrode Array (List Separately In Addition To	avoid post-service review.			
	Code For Primary Procedure)		2/15/2024		Add effective 02/15/2024
	Destruction By Neurolytic Agent Genicular Nerve Branches	MP Criteria: Procedure/service reviewed against Medical			
64624	Including Imaging Guidance When Performed	Policy Criteria. Submit for Recommended Clinical Review to	_		_
		avoid post-service review.			_
	Radiofrequency Ablation Nerves Innervating The Sacroiliac	MP Criteria: Procedures/services reviewed against Medical			
64625	Joint With Image Guidance (le Fluoroscopy Or Computed	Policy Criteria. Submit for Recommended Clinical Review to			
	Tomography)	avoid post-service review by Carelon.	_	_	_
	Thermal Destruction Of Intraosseous Basivertebral Nerve	EIU: Procedure/service not reimbursed by the Plan. Not			
64628	Including All Imaging Guidance; First 2 Vertebral Bodies	subject to pre-service review. Check EIU policy, which is			
	Lumbar Or Sacral	one of our Clinical Payment and Coding Policy (CPCP).	_		-
	Thermal Destruction Of Intraosseous Basivertebral Nerve				
	Including All Imaging Guidance; Each Additional Vertebral	EIU: Procedure/service not reimbursed by the Plan. Not			
64629	Body Lumbar Or Sacral (List Separately In Addition To Code	subject to pre-service review. Check EIU policy, which is	_	_	-
	For Primary Procedure)	one of our Clinical Payment and Coding Policy (CPCP).			
	Destruction By Neurolytic Agent Paravertebral Facet Joint	MP Criteria: Procedures/services reviewed against Medical			
64633	Nerve(S) With Imaging Guidance (Fluoroscopy Or Ct);	Policy Criteria. Submit for Recommended Clinical Review to			
0 1033	Cervical Or Thoracic Single Facet Joint	avoid post-service review by Carelon.	_	-	-
	Destruction By Neurolytic Agent Paravertebral Facet Joint	avoid post service review by earcion.			
	Nerve(S) With Imaging Guidance (Fluoroscopy Or Ct);	MP Criteria: Procedures/services reviewed against Medical			
64634	Cervical Or Thoracic Each Additional Facet Joint (List	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Separately In Addition To Code For Primary Procedure)	avoid post-service review by Carelon.			
	Destruction By Neurolytic Agent Paravertebral Facet Joint	MP Criteria: Procedures/services reviewed against Medical			
64635	Nerve(S) With Imaging Guidance (Fluoroscopy Or Ct);	Policy Criteria. Submit for Recommended Clinical Review to			
0.000	Lumbar Or Sacral Single Facet Joint	avoid post-service review by Carelon.	_	_	-
	Destruction By Neurolytic Agent Paravertebral Facet Joint				
	Nerve(S) With Imaging Guidance (Fluoroscopy Or Ct);	MP Criteria: Procedures/services reviewed against Medical			
64636	Lumbar Or Sacral Each Additional Facet Joint (List	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Separately In Addition To Code For Primary Procedure)	avoid post-service review by Carelon.			
	Destruction By Neurolytic Agent; Other Peripheral Nerve Or	MP Criteria: Procedure/service reviewed against Medical			
64640	Branch	Policy Criteria. Submit for Recommended Clinical Review to			
04040	Didicii	· ·	-	-	-
	Neuroplasty And/Or Transposition; Cranial Nerve (Specify)	avoid post-service review. MP Criteria: Procedures/services reviewed against Medical			
64716	Neuropiasty Ana, or Transposition, Cramar Nerve (Specify)	Policy Criteria. Submit for Recommended Clinical Review to			
04710		· ·	_	-	-
	Transaction Or Applicion Of: Supragrhital Name	avoid post-service review by BCBS. MP Criteria: Procedures/services reviewed against Medical			
64722	Transection Or Avulsion Of; Supraorbital Nerve	_			
64732		Policy Criteria. Submit for Recommended Clinical Review to	-	-	-
		avoid post-service review by BCBS.			

	Transection Or Avulsion Of; Infraorbital Nerve	MP Criteria: Procedures/services reviewed against Medical			
64734		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by BCBS.			
	Transection Or Avulsion Of Other Cranial Nerve Extradural	MP Criteria: Procedures/services reviewed against Medical			
64771		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by BCBS.			
	Unlisted Procedure Nervous System	Unlisted: Procedure/service not specifically defined or			
64999		classified, maybe subject to contract/clinical review. Prior			
04939		Authorization may be required per contract agreement.	_	-	_
		, , ,			
65760	Keratomileusis	Non Covered: Procedure/service not covered by the Plan.			
03700		Not subject to pre-service review.	-	-	_
	Keratoprosthesis	MP Criteria: Procedure/service reviewed against Medical			
65770		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Implantation Of Intrastromal Corneal Ring Segments	MP Criteria: Procedure/service reviewed against Medical			
65785		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Transluminal Dilation Of Aqueous Outflow Canal (Eg	MP Criteria: Procedure/service reviewed against Medical			
66174	Canaloplasty); Without Retention Of Device Or Stent	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Transluminal Dilation Of Aqueous Outflow Canal (Eg	MP Criteria: Procedure/service reviewed against Medical			
66175	Canaloplasty); With Retention Of Device Or Stent	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Aqueous Shunt To Extraocular Equatorial Plate Reservoir	MP Criteria: Procedure/service reviewed against Medical			
66179	External Approach; Without Graft	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Aqueous Shunt To Extraocular Equatorial Plate Reservoir	MP Criteria: Procedure/service reviewed against Medical			
66180	External Approach; With Graft	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Insertion Of Anterior Segment Aqueous Drainage Device	MP Criteria: Procedure/service reviewed against Medical			
66183	Without Extraocular Reservoir External Approach	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Extracapsular Cataract Removal With Insertion Of				
	Intraocular Lens Prosthesis (1-Stage Procedure) Manual Or				
	Mechanical Technique (Eg Irrigation And Aspiration Or				
	Phacoemulsification) Complex Requiring Devices Or				
	Techniques Not Generally Used In Routine Cataract Surgery	MP Criteria: Procedure/service reviewed against Medical			
66989	(Eg Iris Expansion Device Suture Support For Intraocular	Policy Criteria. Submit for Recommended Clinical Review to			
	Lens Or Primary Posterior Capsulorrhexis) Or Performed On	avoid post-service review.	_	<u></u>	_
	Patients In The Amblyogenic Developmental Stage; With				
	Insertion Of Intraocular (Eg Trabecular Meshwork				
	Supraciliary Suprachoroidal) Anterior Segment Aqueous				
	Drainage Device Without Extraocular Reservoir Internal				
	Annroach One Or More				

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· ·	Cataract Removal With Insertion Of				
	ens Prosthesis (1 Stage Procedure) Manual Or				
I I	echnique (Eg Irrigation And Aspiration Or	MP Criteria: Procedure/service reviewed against Medical			
	ication); With Insertion Of Intraocular (Eg	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
Trabecular M	eshwork Supraciliary Suprachoroidal) Anterior	avoid post-service review.			
Segment Aqu	eous Drainage Device Without Extraocular				
	ernal Approach One Or More				
66999 Unlisted Proc	edure Anterior Segment Of Eye	Unlisted: Procedure/service not specifically defined or			
00333		classified, maybe subject to contract/clinical review.	-	-	_
Implantation	Of Intravitreal Drug Delivery System (Eg	MP Criteria: Procedure/service reviewed against Medical			
67027 Ganciclovir In	nplant) Includes Concomitant Removal Of	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
Vitreous		avoid post-service review.			
Destruction C	of Localized Lesion Of Retina (Eg Macular	MP Criteria: Procedures/services reviewed against Medical			
67218 Edema Tumo	ors) 1 Or More Sessions; Radiation By	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
Implantation	Of Source (Includes Removal Of Source)	avoid post-service review by Carelon.			
67299 Unlisted Proc	edure Posterior Segment	Unlisted: Procedure/service not specifically defined or			
67299		classified, maybe subject to contract/clinical review.	-	-	-
Unlisted Proc	edure Extraocular Muscle	Unlisted: Procedure/service not specifically defined or			
67399		classified, maybe subject to contract/clinical review.	-	-	_
Suprachoroid	al Space Injection Of Pharmacologic Agent	MP Criteria: Procedure/service reviewed against Medical			
67516 (Separate Pro	ocedure)	Policy Criteria. Submit for Recommended Clinical Review to			
(,	·····	avoid post-service review.	2/15/2024	_	Add effective 02/15/2024
Unlisted Proc	edure Orbit	Unlisted: Procedure/service not specifically defined or			
67599		classified, maybe subject to contract/clinical review.	-	-	_
Repair Of Bro	w Ptosis (Supraciliary Mid-Forehead Or	MP Criteria: Procedure/service reviewed against Medical			
Coronal Appr		Policy Criteria. Submit for Recommended Clinical Review to			
67900 CSTSTIAT (PPT)	545,	avoid post-service review. Prior Authorization may be	_	_	_
		required per contract agreement.			
Repair Of Ble	pharoptosis; Frontalis Muscle Technique With	MP Criteria: Procedure/service reviewed against Medical			
I ' '	ner Material (Eg. Banked Fascia)	Policy Criteria. Submit for Recommended Clinical Review to			
Suture of oth	iei Materiai (Eg. Barikeu i ascia)	avoid post-service review.	-	-	-
Renair Of Rie	pharoptosis; Frontalis Muscle Technique With	MP Criteria: Procedure/service reviewed against Medical			
' '	ascial Sling (Includes Obtaining Fascia)	Policy Criteria. Submit for Recommended Clinical Review to			
Autologous Fa	ascial Sillig (iliciades Obtailling Fascia)	avoid post-service review.	-	-	_
Popair Of Pla	pharoptosis; (Tarso) Levator Resection Or	MP Criteria: Procedure/service reviewed against Medical			
	,	Policy Criteria. Submit for Recommended Clinical Review to			
Advancement	t Internal Approach	·	-	-	-
Danair Of Dia	pharoptosis; (Tarso) Levator Resection Or	avoid post-service review. MP Criteria: Procedure/service reviewed against Medical			
67904 Advancement	t External Approach	Policy Criteria. Submit for Recommended Clinical Review to	_	-	_
2		avoid post-service review.			
	pharoptosis; Superior Rectus Technique With	MP Criteria: Procedure/service reviewed against Medical			
67906 Fascial Sling (Includes Obtaining Fascia)	Policy Criteria. Submit for Recommended Clinical Review to	-	-	_
		avoid post-service review.			
Repair Of Ble	pharoptosis; Conjunctivo-Tarso-Muller'S	MP Criteria: Procedure/service reviewed against Medical			
	• • •				
I ' '	or Resection (Eg Fasanella-Servat Type)	Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_

	Unlisted Presedure Fuelids	Unlisted: Procedure/service not specifically defined or			
67999	Unlisted Procedure Eyelids	classified, maybe subject to contract/clinical review.	_	_	_
	Unlisted Procedure Conjunctiva	Unlisted: Procedure/service not specifically defined or			
68399	omisted Procedure Conjunctiva	classified, maybe subject to contract/clinical review.	_	_	_
	Unlisted Procedure Lacrimal System	Unlisted: Procedure/service not specifically defined or			
68899	omisted i recedure addimistrações.	classified, maybe subject to contract/clinical review.	_	_	-
	Ear Piercing	MP Criteria: Procedure/service reviewed against Medical			
69090		Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review.	_	_	_
	Otoplasty Protruding Ear With Or Without Size Reduction	MP Criteria: Procedure/service reviewed against Medical			
69300		Policy Criteria. Submit for Recommended Clinical Review to	_		_
		avoid post-service review.			
60200	Unlisted Procedure External Ear	Unlisted: Procedure/service not specifically defined or			
69399		classified, maybe subject to contract/clinical review.	_	-	-
	Nasopharyngoscopy Surgical With Dilation Of Eustachian	MP Criteria: Procedure/service reviewed against Medical			
69705	Tube (le Balloon Dilation); Unilateral	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Nasopharyngoscopy Surgical With Dilation Of Eustachian	MP Criteria: Procedure/service reviewed against Medical			
69706	Tube (le Balloon Dilation); Bilateral	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Implantation Osseointegrated Implant Skull; With	MP Criteria: Procedure/service reviewed against Medical			
69714	Percutaneous Attachment To External Speech Processor	Policy Criteria. Submit for Recommended Clinical Review to			
03711		avoid post-service review. Prior Authorization may be	_	_	-
		required per contract agreement.			
	Implantation Osseointegrated Implant Skull; With Magnetic				
	Transcutaneous Attachment To External Speech Processor	MP Criteria: Procedure/service reviewed against Medical			
69716	Within The Mastoid And/Or Resulting In Removal Of Less	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Than 100 Sq Mm Surface Area Of Bone Deep To The Outer	avoid post-service review.			
	Cranial Cortex	MD Collection December 1 to 1 t			
	Replacement (Including Removal Of Existing Device)	MP Criteria: Procedure/service reviewed against Medical			
69717	Osseointegrated Implant Skull; With Percutaneous	Policy Criteria. Submit for Recommended Clinical Review to	_		_
	Attachment To External Speech Processor	avoid post-service review. Prior Authorization may be			
	Depletoment (Including Demoval Of Existing Device)	required per contract agreement.			
	Replacement (Including Removal Of Existing Device)				
	Osseointegrated Implant Skull; With Magnetic Transcutaneous Attachment To External Speech Processor	MP Criteria: Procedure/service reviewed against Medical			
69719	Within The Mastoid And/Or Involving A Bony Defect Less	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Than 100 Sq Mm Surface Area Of Bone Deep To The Outer	avoid post-service review.			
	·				
	Cranial Cortex Removal Entire Osseointegrated Implant Skull; With				
	Magnetic Transcutaneous Attachment To External Speech	MP Criteria: Procedure/service reviewed against Medical			
69728	Processor Outside The Mastoid And Involving A Bony Defect				
	Greater Than Or Equal To 100 Sq Mm Surface Area Of Bone	avoid post-service review.	_	_	-
	Deep To The Outer Cranial Cortex	2.2.2 p.230 000 100 1000000			
	Deep to the outer cramar cortex				

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	Replacement (Including Removal Of Existing Device)				
	Osseointegrated Implant Skull; With Magnetic	MP Criteria: Procedure/service reviewed against Medical			
C0720	Transcutaneous Attachment To External Speech Processor	·			
69730	Outside The Mastoid And Involving A Bony Defect Greater	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Than Or Equal To 100 Sq Mm Surface Area Of Bone Deep To	avoid post-service review.			
	The Outer Cranial Cortex				
	Unlisted Procedure Middle Ear	Unlisted: Procedure/service not specifically defined or			
69799	omisted Frocedure Mindre Edi	classified, maybe subject to contract/clinical review.	_	_	_
	Cochlear Device Implantation With Or Without	MP Criteria: Procedure/service reviewed against Medical			
	·	Policy Criteria. Submit for Recommended Clinical Review to			
69930	Mastoidectomy	•	_	_	_
		avoid post-service review. Prior Authorization may be			
	U. II	required per contract agreement.			
69949	Unlisted Procedure Inner Ear	Unlisted: Procedure/service not specifically defined or			
		classified, maybe subject to contract/clinical review.	_	_	_
69979	Unlisted Procedure Temporal Bone Middle Fossa Approach	The state of the s			
		classified, maybe subject to contract/clinical review.	-	-	-
	Computed Tomography Head Or Brain; Without Contrast	MP Criteria: Procedures/services reviewed against Medical			
70450	Material	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by BCBS.			
	Computed Tomography Head Or Brain; With Contrast	MP Criteria: Procedures/services reviewed against Medical			
70460	Material(S)	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by BCBS.			
	Computed Tomography Head Or Brain; Without Contrast	MP Criteria: Procedures/services reviewed against Medical			
70470	Material Followed By Contrast Material(S) And Further	Policy Criteria. Submit for Recommended Clinical Review to	_	_	
	Sections	avoid post-service review by BCBS.			
	Computed Tomography Orbit Sella Or Posterior Fossa Or	MP Criteria: Procedures/services reviewed against Medical			
70480	Outer Middle Or Inner Ear; Without Contrast Material	Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review by BCBS.	_	_	_
	Computed Tomography Orbit Sella Or Posterior Fossa Or	MP Criteria: Procedures/services reviewed against Medical			
70481	Outer Middle Or Inner Ear; With Contrast Material(S)	Policy Criteria. Submit for Recommended Clinical Review to			
70.01	outer whome of finite Ear, with contrast material(s)	avoid post-service review by BCBS.	_	-	_
	Computed Tomography Orbit Sella Or Posterior Fossa Or	MP Criteria: Procedures/services reviewed against Medical			
70482	Outer Middle Or Inner Ear; Without Contrast Material	Policy Criteria. Submit for Recommended Clinical Review to			
70402	· · · · · · · · · · · · · · · · · · ·	· ·	_	-	-
	Followed By Contrast Material(S) And Further Sections	avoid post-service review by BCBS. MP Criteria: Procedures/services reviewed against Medical			
70406	Computed Tomography Maxillofacial Area; Without	·			
70486	Contrast Material	Policy Criteria. Submit for Recommended Clinical Review to	-	-	-
		avoid post-service review by BCBS.			
	Computed Tomography Maxillofacial Area; With Contrast	MP Criteria: Procedures/services reviewed against Medical			
70487	Material(S)	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by BCBS.			
	Computed Tomography Maxillofacial Area; Without	MP Criteria: Procedures/services reviewed against Medical			
70488	Contrast Material Followed By Contrast Material(S) And	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Further Sections	avoid post-service review by BCBS.			
	Computed Tomography Soft Tissue Neck; Without Contrast	MP Criteria: Procedures/services reviewed against Medical			
70490	Material	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by BCBS.			

	Computed Tomography Soft Tissue Neck; With Contrast	MP Criteria: Procedures/services reviewed against Medical			
70491	Material(S)	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by BCBS.			
	Computed Tomography Soft Tissue Neck; Without Contrast	MP Criteria: Procedures/services reviewed against Medical			
70492	Material Followed By Contrast Material(S) And Further	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Sections	avoid post-service review by BCBS.			
	Computed Tomographic Angiography Head With Contrast	MP Criteria: Procedures/services reviewed against Medical			
70496	Material(S) Including Noncontrast Images If Performed	Policy Criteria. Submit for Recommended Clinical Review to	_	_	
	And Image Postprocessing	avoid post-service review by BCBS.			
	Computed Tomographic Angiography Neck With Contrast	MP Criteria: Procedures/services reviewed against Medical			
70498	Material(S) Including Noncontrast Images If Performed	Policy Criteria. Submit for Recommended Clinical Review to			
	And Image Postprocessing	avoid post-service review by BCBS.	_		
	Magnetic Resonance (Eg Proton) Imaging Orbit Face	MP Criteria: Procedures/services reviewed against Medical			
70540	And/Or Neck; Without Contrast Material(S)	Policy Criteria. Submit for Recommended Clinical Review to			
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	avoid post-service review by BCBS.	_	<u></u>	_
	Magnetic Resonance (Eg. Proton) Imaging Orbit Face	MP Criteria: Procedures/services reviewed against Medical			
70542	And/Or Neck; With Contrast Material(S)	Policy Criteria. Submit for Recommended Clinical Review to			
	, , , , , , , , , , , , , , , , , , , ,	avoid post-service review by BCBS.	_	_	_
	Magnetic Resonance (Eg Proton) Imaging Orbit Face	MP Criteria: Procedures/services reviewed against Medical			
70543	And/Or Neck; Without Contrast Material(S) Followed By	Policy Criteria. Submit for Recommended Clinical Review to			
, 65 .5	Contrast Material(S) And Further Sequences	avoid post-service review by BCBS.	_	_	_
	Magnetic Resonance Angiography Head; Without Contrast	MP Criteria: Procedures/services reviewed against Medical			
70544	Material(S)	Policy Criteria. Submit for Recommended Clinical Review to			
70311	Material(3)	avoid post-service review by BCBS.	_	-	_
	Magnetic Resonance Angiography Head; With Contrast	MP Criteria: Procedures/services reviewed against Medical			
70545	Material(S)	Policy Criteria. Submit for Recommended Clinical Review to			
, 65 .5	Material(3)	avoid post-service review by BCBS.	_	_	_
	Magnetic Resonance Angiography Head; Without Contrast	MP Criteria: Procedures/services reviewed against Medical			
70546	Material(S) Followed By Contrast Material(S) And Further	Policy Criteria. Submit for Recommended Clinical Review to			
70310	Sequences	avoid post-service review by BCBS.	_	_	_
	Magnetic Resonance Angiography Neck; Without Contrast	MP Criteria: Procedures/services reviewed against Medical			
70547	Material(S)	Policy Criteria. Submit for Recommended Clinical Review to			
70347	waterial(3)	avoid post-service review by BCBS.	-	-	-
	Magnetic Resonance Angiography Neck; With Contrast	MP Criteria: Procedures/services reviewed against Medical			
70548	Material(S)	Policy Criteria. Submit for Recommended Clinical Review to			
70348	Material(3)	avoid post-service review by BCBS.	_	-	-
	Magnetic Resonance Angiography Neck; Without Contrast	MP Criteria: Procedures/services reviewed against Medical			
70549		Policy Criteria. Submit for Recommended Clinical Review to			
70349	Material(S) Followed By Contrast Material(S) And Further	·	_	_	-
	Sequences	avoid post-service review by BCBS. MP Criteria: Procedures/services reviewed against Medical			
70554	Magnetic Resonance (Eg Proton) Imaging Brain (Including				
70551	Brain Stem); Without Contrast Material	Policy Criteria. Submit for Recommended Clinical Review to	-	-	-
	Magnetic Recogning (Fg. Broton) Imaging Broin (Including	avoid post-service review by BCBS.		-	
70552	Magnetic Resonance (Eg Proton) Imaging Brain (Including	MP Criteria: Procedures/services reviewed against Medical			
70552	Brain Stem); With Contrast Material(S)	Policy Criteria. Submit for Recommended Clinical Review to	-	-	-
	Manager Bases of Facility Name of State Control of State	avoid post-service review by BCBS.		-	
70552	Magnetic Resonance (Eg Proton) Imaging Brain (Including	MP Criteria: Procedures/services reviewed against Medical			
70553	Brain Stem); Without Contrast Material Followed By	Policy Criteria. Submit for Recommended Clinical Review to	-	-	-
	Contrast Material(S) And Further Sequences	avoid post-service review by BCBS.		1	

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70554	Magnetic Resonance Imaging Brain Functional Mri; Including Test Selection And Administration Of Repetitive Body Part Movement And/Or Visual Stimulation Not Requiring Physician Or Psychologist Administration	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS.	-	-	-
70555	Magnetic Resonance Imaging Brain Functional Mri; Requiring Physician Or Psychologist Administration Of Entire Neurofunctional Testing	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS.	-	-	-
71250	Computed Tomography Thorax Diagnostic; Without Contrast Material	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS.	-	-	-
71260	Computed Tomography Thorax Diagnostic; With Contrast Material(S)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS.	_	-	-
71270	Computed Tomography Thorax Diagnostic; Without Contrast Material Followed By Contrast Material(S) And Further Sections	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS.	_	-	-
71271	Computed Tomography Thorax Low Dose For Lung Cancer Screening Without Contrast Material(S)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS.	_	-	-
71275	Computed Tomographic Angiography Chest (Noncoronary) With Contrast Material(S) Including Noncontrast Images If Performed And Image Postprocessing	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS.	-	-	-
71550	Magnetic Resonance (Eg Proton) Imaging Chest (Eg For Evaluation Of Hilar And Mediastinal Lymphadenopathy); Without Contrast Material(S)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS.	-	-	-
71551	Magnetic Resonance (Eg Proton) Imaging Chest (Eg For Evaluation Of Hilar And Mediastinal Lymphadenopathy); With Contrast Material(S)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS.	-	-	-
71552	Magnetic Resonance (Eg Proton) Imaging Chest (Eg For Evaluation Of Hilar And Mediastinal Lymphadenopathy); Without Contrast Material(S) Followed By Contrast Material(S) And Further Sequences	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS.	-	-	-
71555	Magnetic Resonance Angiography Chest (Excluding Myocardium) With Or Without Contrast Material(S)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS.	-	-	-
72125	Computed Tomography Cervical Spine; Without Contrast Material	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS.	-	-	-
72126	Computed Tomography Cervical Spine; With Contrast Material	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS.	-	-	-
72127	Computed Tomography Cervical Spine; Without Contrast Material Followed By Contrast Material(S) And Further Sections	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS.	-	-	-

	Computed Tomography Thoracic Spine; Without Contrast	MP Criteria: Procedures/services reviewed against Medical			
72128	Material	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by BCBS.			
	Computed Tomography Thoracic Spine; With Contrast	MP Criteria: Procedures/services reviewed against Medical			
72129	Material	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by BCBS.			
	Computed Tomography Thoracic Spine; Without Contrast	MP Criteria: Procedures/services reviewed against Medical			
72130	Material Followed By Contrast Material(S) And Further	Policy Criteria. Submit for Recommended Clinical Review to	_		L
	Sections	avoid post-service review by BCBS.			
	Computed Tomography Lumbar Spine; Without Contrast	MP Criteria: Procedures/services reviewed against Medical			
72131	Material	Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review by BCBS.			
	Computed Tomography Lumbar Spine; With Contrast	MP Criteria: Procedures/services reviewed against Medical			
72132	Material	Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review by BCBS.	_		_
	Computed Tomography Lumbar Spine; Without Contrast	MP Criteria: Procedures/services reviewed against Medical			
72133	Material Followed By Contrast Material(S) And Further	Policy Criteria. Submit for Recommended Clinical Review to			
	Sections	avoid post-service review by BCBS.	_	_	_
	Magnetic Resonance (Eg Proton) Imaging Spinal Canal And				
72141	Contents Cervical; Without Contrast Material	Policy Criteria. Submit for Recommended Clinical Review to			
/	Contents Cervical, Without Contrast Material	avoid post-service review by BCBS.	_	-	_
	Magnetic Resonance (Eg Proton) Imaging Spinal Canal And	MP Criteria: Procedures/services reviewed against Medical			
72142	Contents Cervical; With Contrast Material(S)	Policy Criteria. Submit for Recommended Clinical Review to			
/	Contents Cervical, with Contrast Material(5)	avoid post-service review by BCBS.	_	-	-
	Magnetic Resonance (Eg Proton) Imaging Spinal Canal And	MP Criteria: Procedures/services reviewed against Medical			
72146	Contents Thoracic; Without Contrast Material	Policy Criteria. Submit for Recommended Clinical Review to			
,	contents moracle, without contrast material	avoid post-service review by BCBS.	_	-	_
	Magnetic Resonance (Eg Proton) Imaging Spinal Canal And				
72147	Contents Thoracic; With Contrast Material(S)	Policy Criteria. Submit for Recommended Clinical Review to			
/211/	Contents moracic, with contrast material(s)	avoid post-service review by BCBS.	_	-	-
	Magnetic Resonance (Eg. Proton) Imaging Spinal Canal And	MP Criteria: Procedures/services reviewed against Medical			
72148	Contents Lumbar; Without Contrast Material	Policy Criteria. Submit for Recommended Clinical Review to			
72110	contents Euribar, Without Contrast Material	avoid post-service review by BCBS.	_	-	-
	Magnetic Resonance (Eg Proton) Imaging Spinal Canal And				
72149	Contents Lumbar; With Contrast Material(S)	Policy Criteria. Submit for Recommended Clinical Review to			
72143	Contents Lumbar, with Contrast Material(3)	avoid post-service review by BCBS.	-	-	-
	Magnetic Resonance (Eg Proton) Imaging Spinal Canal And	MP Criteria: Procedures/services reviewed against Medical			
72156	Contents Without Contrast Material Followed By Contrast	Policy Criteria. Submit for Recommended Clinical Review to			
72130	Material(S) And Further Sequences; Cervical	avoid post-service review by BCBS.	_	-	_
72157	Contents Without Contrast Material Followed By Contrast	Policy Criteria. Submit for Recommended Clinical Review to			
/213/	· ·	· ·	_	-	_
	Material(S) And Further Sequences; Thoracic Magnetic Resonance (Eg Proton) Imaging Spinal Canal And	avoid post-service review by BCBS. MP Criteria: Procedures (services reviewed against Medical			
72158		Policy Criteria. Submit for Recommended Clinical Review to			
/2138	Contents Without Contrast Material Followed By Contrast	· ·	-	-	-
	Material(S) And Further Sequences; Lumbar	avoid post-service review by BCBS.			
72150	Magnetic Resonance Angiography Spinal Canal And	MP Criteria: Procedures/services reviewed against Medical			
72159	Contents With Or Without Contrast Material(S)	Policy Criteria. Submit for Recommended Clinical Review to	-	-	-
		avoid post-service review by BCBS.			<u> </u>

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		MP Criteria: Procedures/services reviewed against Medical			
72191	Material(S) Including Noncontrast Images If Performed	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	And Image Postprocessing	avoid post-service review by BCBS.			
	Computed Tomography Pelvis; Without Contrast Material	MP Criteria: Procedures/services reviewed against Medical			
72192		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by BCBS.			
	Computed Tomography Pelvis; With Contrast Material(S)	MP Criteria: Procedures/services reviewed against Medical			
72193		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by BCBS.			
	Computed Tomography Pelvis; Without Contrast Material	MP Criteria: Procedures/services reviewed against Medical			
72194	Followed By Contrast Material(S) And Further Sections	Policy Criteria. Submit for Recommended Clinical Review to		L	_
		avoid post-service review by BCBS.			
	Magnetic Resonance (Eg Proton) Imaging Pelvis; Without	MP Criteria: Procedures/services reviewed against Medical			
72195	Contrast Material(S)	Policy Criteria. Submit for Recommended Clinical Review to			
	` '	avoid post-service review by BCBS.	_	_	_
	Magnetic Resonance (Eg Proton) Imaging Pelvis; With	MP Criteria: Procedures/services reviewed against Medical			
72196	Contrast Material(S)	Policy Criteria. Submit for Recommended Clinical Review to			
	(4)	avoid post-service review by BCBS.	_	_	_
	Magnetic Resonance (Eg Proton) Imaging Pelvis; Without	MP Criteria: Procedures/services reviewed against Medical			
72197	Contrast Material(S) Followed By Contrast Material(S) And	Policy Criteria. Submit for Recommended Clinical Review to			
, 223,	Further Sequences	avoid post-service review by BCBS.	_	_	-
	Magnetic Resonance Angiography Pelvis With Or Without	MP Criteria: Procedures/services reviewed against Medical			
72198	Contrast Material(S)	Policy Criteria. Submit for Recommended Clinical Review to			
72130	Contrast iviaterial(3)	avoid post-service review by BCBS.	-	-	-
	Computed Tomography Upper Extremity; Without Contrast	MP Criteria: Procedures/services reviewed against Medical			
73200	Material	Policy Criteria. Submit for Recommended Clinical Review to			
73200	iviateriai	avoid post-service review by BCBS.	_	-	-
	Computed Tomography Hanas Futromity With Contract	MP Criteria: Procedures/services reviewed against Medical			+
73201	Computed Tomography Upper Extremity; With Contrast	Policy Criteria. Submit for Recommended Clinical Review to			
/3201	Material(S)	'	-	-	-
	0 17 1 1 5 1 1 10 1 1	avoid post-service review by BCBS.			
	P	MP Criteria: Procedures/services reviewed against Medical			
73202	Material Followed By Contrast Material(S) And Further	Policy Criteria. Submit for Recommended Clinical Review to	_	_	-
	Sections	avoid post-service review by BCBS.			
	Computed Tomographic Angiography Upper Extremity	MP Criteria: Procedures/services reviewed against Medical			
73206	With Contrast Material(S) Including Noncontrast Images If	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Performed And Image Postprocessing	avoid post-service review by BCBS.			
	Magnetic Resonance (Eg Proton) Imaging Upper Extremity	MP Criteria: Procedures/services reviewed against Medical			
73218	Other Than Joint; Without Contrast Material(S)	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by BCBS.			
	Magnetic Resonance (Eg Proton) Imaging Upper Extremity	MP Criteria: Procedures/services reviewed against Medical			
73219	Other Than Joint; With Contrast Material(S)	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by BCBS.			
	Magnetic Resonance (Eg Proton) Imaging Upper Extremity	MP Criteria: Procedures/services reviewed against Medical			
73220		Policy Criteria. Submit for Recommended Clinical Review to			
	Contrast Material(S) And Further Sequences	avoid post-service review by BCBS.	<u> </u>	Ī	
	Magnetic Resonance (Eg. Proton) Imaging Any Joint Of	MP Criteria: Procedures/services reviewed against Medical			
73221	Upper Extremity; Without Contrast Material(S)	Policy Criteria. Submit for Recommended Clinical Review to			
· -=	oppo. Extremity, without contract material(5)	avoid post-service review by BCBS.	-	-	-

	Magnetic Resonance (Eg Proton) Imaging Any Joint Of	MP Criteria: Procedures/services reviewed against Medical			
73222	Upper Extremity; With Contrast Material(S)	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by BCBS.			
	Magnetic Resonance (Eg Proton) Imaging Any Joint Of	MP Criteria: Procedures/services reviewed against Medical			
73223	Upper Extremity; Without Contrast Material(S) Followed By	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Contrast Material(S) And Further Sequences	avoid post-service review by BCBS.			
	Magnetic Resonance Angiography Upper Extremity With Or	MP Criteria: Procedures/services reviewed against Medical			
73225	Without Contrast Material(S)	Policy Criteria. Submit for Recommended Clinical Review to	_	_	
		avoid post-service review by BCBS.			
	Computed Tomography Lower Extremity; Without Contrast	MP Criteria: Procedures/services reviewed against Medical			
73700	Material	Policy Criteria. Submit for Recommended Clinical Review to	_	_	
		avoid post-service review by BCBS.			
	Computed Tomography Lower Extremity; With Contrast	MP Criteria: Procedures/services reviewed against Medical			
73701	Material(S)	Policy Criteria. Submit for Recommended Clinical Review to	_	_	
		avoid post-service review by BCBS.			
	Computed Tomography Lower Extremity; Without Contrast	MP Criteria: Procedures/services reviewed against Medical			
73702	Material Followed By Contrast Material(S) And Further	Policy Criteria. Submit for Recommended Clinical Review to	_	_	
	Sections	avoid post-service review by BCBS.			
	Computed Tomographic Angiography Lower Extremity	MP Criteria: Procedures/services reviewed against Medical			
73706	With Contrast Material(S) Including Noncontrast Images If	Policy Criteria. Submit for Recommended Clinical Review to			
	Performed And Image Postprocessing	avoid post-service review by BCBS.			
	Magnetic Resonance (Eg Proton) Imaging Lower Extremity	MP Criteria: Procedures/services reviewed against Medical			
73718	Other Than Joint; Without Contrast Material(S)	Policy Criteria. Submit for Recommended Clinical Review to	_		L
		avoid post-service review by BCBS.			
	Magnetic Resonance (Eg Proton) Imaging Lower Extremity	MP Criteria: Procedures/services reviewed against Medical			
73719	Other Than Joint; With Contrast Material(S)	Policy Criteria. Submit for Recommended Clinical Review to	_	_	
		avoid post-service review by BCBS.			
	Magnetic Resonance (Eg Proton) Imaging Lower Extremity	MP Criteria: Procedures/services reviewed against Medical			
73720	Other Than Joint; Without Contrast Material(S) Followed By	Policy Criteria. Submit for Recommended Clinical Review to	_	_	
	Contrast Material(S) And Further Sequences	avoid post-service review by BCBS.			
	Magnetic Resonance (Eg Proton) Imaging Any Joint Of	MP Criteria: Procedures/services reviewed against Medical			
73721	Lower Extremity; Without Contrast Material	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by BCBS.			
	Magnetic Resonance (Eg Proton) Imaging Any Joint Of	MP Criteria: Procedures/services reviewed against Medical			
73722	Lower Extremity; With Contrast Material(S)	Policy Criteria. Submit for Recommended Clinical Review to	_	_	
		avoid post-service review by BCBS.			
	Magnetic Resonance (Eg Proton) Imaging Any Joint Of	MP Criteria: Procedures/services reviewed against Medical			
73723	Lower Extremity; Without Contrast Material(S) Followed By	Policy Criteria. Submit for Recommended Clinical Review to	_	_	
	Contrast Material(S) And Further Sequences	avoid post-service review by BCBS.			
	Magnetic Resonance Angiography Lower Extremity With Or	MP Criteria: Procedures/services reviewed against Medical			
73725	Without Contrast Material(S)	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by BCBS.			
	Computed Tomography Abdomen; Without Contrast	MP Criteria: Procedures/services reviewed against Medical			
74150	Material	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by BCBS.			
	Computed Tomography Abdomen; With Contrast	MP Criteria: Procedures/services reviewed against Medical			
74160	Material(S)	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by BCBS.			

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	Computed Tomography Abdomen; Without Contrast	MP Criteria: Procedures/services reviewed against Medical		
74170	Material Followed By Contrast Material(S) And Further	Policy Criteria. Submit for Recommended Clinical Review to	-	_
	Sections	avoid post-service review by BCBS.		
	Computed Tomographic Angiography Abdomen And Pelvis	MP Criteria: Procedures/services reviewed against Medical		
74174	With Contrast Material(S) Including Noncontrast Images If	Policy Criteria. Submit for Recommended Clinical Review to	_	_
	Performed And Image Postprocessing	avoid post-service review by BCBS.		
	Computed Tomographic Angiography Abdomen With	MP Criteria: Procedures/services reviewed against Medical		
74175	Contrast Material(S) Including Noncontrast Images If	Policy Criteria. Submit for Recommended Clinical Review to _	_	_
	Performed And Image Postprocessing	avoid post-service review by BCBS.		
	Computed Tomography Abdomen And Pelvis; Without	MP Criteria: Procedures/services reviewed against Medical		
74176	Contrast Material	Policy Criteria. Submit for Recommended Clinical Review to _	_	_
		avoid post-service review by BCBS.		
	Computed Tomography Abdomen And Pelvis; With Contrast	MP Criteria: Procedures/services reviewed against Medical		
74177	Material(S)	Policy Criteria. Submit for Recommended Clinical Review to		
		avoid post-service review by BCBS.		_
	Computed Tomography Abdomen And Pelvis; Without			
	Contrast Material In One Or Both Body Regions Followed By	MP Criteria: Procedures/services reviewed against Medical		
74178	Contrast Material(S) And Further Sections In One Or Both	Policy Criteria. Submit for Recommended Clinical Review to	_	_
	Body Regions	avoid post-service review by BCBS.		
	Magnetic Resonance (Eg Proton) Imaging Abdomen;	MP Criteria: Procedures/services reviewed against Medical		
74181	Without Contrast Material(S)	Policy Criteria. Submit for Recommended Clinical Review to		
, ,101	Without contract Material(5)	avoid post-service review by BCBS.	-	-
	Magnetic Resonance (Eg Proton) Imaging Abdomen; With	MP Criteria: Procedures/services reviewed against Medical		
74182	Contrast Material(S)	Policy Criteria. Submit for Recommended Clinical Review to		
74102	Contrast Material(3)	avoid post-service review by BCBS.	-	-
	Magnetic Resonance (Eg Proton) Imaging Abdomen;	MP Criteria: Procedures/services reviewed against Medical		
74183	Without Contrast Material(S) Followed By With Contrast	Policy Criteria. Submit for Recommended Clinical Review to		
74103	· · ·	avoid post-service review by BCBS.	-	-
	Material(S) And Further Sequences Magnetic Resonance Angiography Abdomen With Or	MP Criteria: Procedures/services reviewed against Medical		
74185		Policy Criteria. Submit for Recommended Clinical Review to		
74103	Without Contrast Material(S)	·	-	-
	Communication Towns are while (Ct) Color acres also Discuss at its	avoid post-service review by BCBS.		
74264	Computed Tomographic (Ct) Colonography Diagnostic	MP Criteria: Procedures/services reviewed against Medical		
74261	Including Image Postprocessing; Without Contrast Material	Policy Criteria. Submit for Recommended Clinical Review to	-	-
	2	avoid post-service review by BCBS.		
74060	Computed Tomographic (Ct) Colonography Diagnostic	MP Criteria: Procedures/services reviewed against Medical		
74262	Including Image Postprocessing; With Contrast Material(S)	Policy Criteria. Submit for Recommended Clinical Review to	-	_
	Including Non-Contrast Images If Performed	avoid post-service review by BCBS.		
	Computed Tomographic (Ct) Colonography Screening	MP Criteria: Procedures/services reviewed against Medical		
74263	Including Image Postprocessing	Policy Criteria. Submit for Recommended Clinical Review to	_	_
		avoid post-service review by BCBS.		
	Magnetic Resonance (Eg Proton) Imaging Fetal Including	MP Criteria: Procedures/services reviewed against Medical		
74712	Placental And Maternal Pelvic Imaging When Performed;	Policy Criteria. Submit for Recommended Clinical Review to _	_	-
	Single Or First Gestation	avoid post-service review by BCBS.		
	Magnetic Resonance (Eg Proton) Imaging Fetal Including	MP Criteria: Procedures/services reviewed against Medical		
74713	Placental And Maternal Pelvic Imaging When Performed;	Policy Criteria. Submit for Recommended Clinical Review to		
/4/13	Each Additional Gestation (List Separately In Addition To	·	-	-
	Code For Primary Procedure)	avoid post-service review by BCBS.		

	Computed Tomographic Angiography Abdominal Aorta And				
	Bilateral Iliofemoral Lower Extremity Runoff With Contrast	MP Criteria: Procedures/services reviewed against Medical			
75635	·	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Material(S) Including Noncontrast Images If Performed	avoid post-service review by BCBS.			
	And Image Postprocessing Transcatheter Therapy Embolization Any Method	MP Criteria: Procedure/service reviewed against Medical			
75894	Radiological Supervision And Interpretation	Policy Criteria. Submit for Recommended Clinical Review to			
73634	Radiological Supervision And Interpretation	avoid post-service review.	2/1/2024	_	Add effective 02/1/2024
	3D Rendering With Interpretation And Reporting Of	avoid post-service review.	2/1/2024		Add effective 02/1/2024
	Computed Tomography Magnetic Resonance Imaging	MP Criteria: Procedures/services reviewed against Medical			
76376	Ultrasound Or Other Tomographic Modality With Image	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Postprocessing Under Concurrent Supervision; Not	avoid post-service review by BCBS.			
	Requiring Image Postprocessing On An Independent				
	Workstation				
	3D Rendering With Interpretation And Reporting Of	NAD Criteria: Dragaduras/san isaa rayiawad against Madical			
76077	Computed Tomography Magnetic Resonance Imaging	MP Criteria: Procedures/services reviewed against Medical			
76377	Ultrasound Or Other Tomographic Modality With Image	Policy Criteria. Submit for Recommended Clinical Review to	_	-	_
	Postprocessing Under Concurrent Supervision; Requiring	avoid post-service review by BCBS.			
	Image Postprocessing On An Independent Workstation				
	Computed Tomography Limited Or Localized Follow-Up	MP Criteria: Procedures/services reviewed against Medical			
76380	Study	Policy Criteria. Submit for Recommended Clinical Review to	_	-	_
		avoid post-service review by BCBS.			
	Magnetic Resonance Spectroscopy	MP Criteria: Procedures/services reviewed against Medical			
76390		Policy Criteria. Submit for Recommended Clinical Review to		-	_
		avoid post-service review by BCBS.			
	Magnetic Resonance (Eg Vibration) Elastography	MP Criteria: Procedures/services reviewed against Medical			
76391		Policy Criteria. Submit for Recommended Clinical Review to		-	_
		avoid post-service review by BCBS.			
76496	Unlisted Fluoroscopic Procedure (Eg Diagnostic	Unlisted: Procedure/service not specifically defined or			
	Interventional)	classified, maybe subject to contract/clinical review.	-	-	_
76497	Unlisted Computed Tomography Procedure (Eg Diagnostic	Unlisted: Procedure/service not specifically defined or			
	Interventional)	classified, maybe subject to contract/clinical review.	-	-	_
76498	Unlisted Magnetic Resonance Procedure (Eg Diagnostic	Unlisted: Procedure/service not specifically defined or			
7 0 13 0	Interventional)	classified, maybe subject to contract/clinical review.	-	-	_
76499	Unlisted Diagnostic Radiographic Procedure	Unlisted: Procedure/service not specifically defined or			
7 0 133		classified, maybe subject to contract/clinical review.	-	-	_
	Ultrasound Transrectal; Prostate Volume Study For	MP Criteria: Procedures/services reviewed against Medical			
76873	Brachytherapy Treatment Planning (Separate Procedure)	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by Carelon.			
	Ultrasonic Guidance For Interstitial Radioelement	MP Criteria: Procedures/services reviewed against Medical			
76965	Application	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by Carelon.			
76999	Unlisted Ultrasound Procedure (Eg Diagnostic	Unlisted: Procedure/service not specifically defined or			
,0333	Interventional)	classified, maybe subject to contract/clinical review.	-	-	_
	Computed Tomography Guidance For Placement Of	MP Criteria: Procedures/services reviewed against Medical			
77014	Radiation Therapy Fields	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by Carelon.			

77046	Magnetic Resonance Imaging Breast Without Contrast Material; Unilateral	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to	_		
		avoid post-service review by BCBS.	_		_
77047	Magnetic Resonance Imaging Breast Without Contrast Material; Bilateral	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS.	-	-	-
77048	Magnetic Resonance Imaging Breast Without And With Contrast Material(S) Including Computer-Aided Detection (Cad Real-Time Lesion Detection Characterization And	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS.	-	-	-
77049	Pharmacokinetic Analysis) When Performed; Unilateral Magnetic Resonance Imaging Breast Without And With Contrast Material(S) Including Computer-Aided Detection (Cad Real-Time Lesion Detection Characterization And Pharmacokinetic Analysis) When Performed; Bilateral	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS.	-	-	-
77078	Computed Tomography Bone Mineral Density Study 1 Or More Sites Axial Skeleton (Eg Hips Pelvis Spine)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS.	-	-	-
77084	Magnetic Resonance (Eg Proton) Imaging Bone Marrow Blood Supply	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS.	-	-	-
77295	3-Dimensional Radiotherapy Plan Including Dose-Volume Histograms	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
77299	Unlisted Procedure Therapeutic Radiology Clinical Treatment Planning	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	_
77301	Intensity Modulated Radiotherapy Plan Including Dose- Volume Histograms For Target And Critical Structure Partial Tolerance Specifications	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
77316	Brachytherapy Isodose Plan; Simple (Calculation[S] Made From 1 To 4 Sources Or Remote Afterloading Brachytherapy 1 Channel) Includes Basic Dosimetry Calculation(S)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
77317	Brachytherapy Isodose Plan; Intermediate (Calculation[S] Made From 5 To 10 Sources Or Remote Afterloading Brachytherapy 2-12 Channels) Includes Basic Dosimetry Calculation(S)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
77318	Brachytherapy Isodose Plan; Complex (Calculation[S] Made From Over 10 Sources Or Remote Afterloading Brachytherapy Over 12 Channels) Includes Basic Dosimetry Calculation(S)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
77338	Multi-Leaf Collimator (Mlc) Device(S) For Intensity Modulated Radiation Therapy (Imrt) Design And Construction Per Imrt Plan	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
77370	Special Medical Radiation Physics Consultation	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-

	Radiation Treatment Delivery Stereotactic Radiosurgery	MP Criteria: Procedures/services reviewed against Medical			
77371	(Srs) Complete Course Of Treatment Of Cranial Lesion(S)	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Consisting Of 1 Session; Multi-Source Cobalt 60 Based	avoid post-service review by Carelon.			
	Radiation Treatment Delivery Stereotactic Radiosurgery	MP Criteria: Procedures/services reviewed against Medical			
77372	(Srs) Complete Course Of Treatment Of Cranial Lesion(S)	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Consisting Of 1 Session; Linear Accelerator Based	avoid post-service review by Carelon.			
	Stereotactic Body Radiation Therapy Treatment Delivery	MP Criteria: Procedures/services reviewed against Medical			
77373	Per Fraction To 1 Or More Lesions Including Image	Policy Criteria. Submit for Recommended Clinical Review to	_		_
	Guidance Entire Course Not To Exceed 5 Fractions	avoid post-service review by Carelon.			
	Intensity Modulated Radiation Treatment Delivery (Imrt)	MP Criteria: Procedures/services reviewed against Medical			
77385	Includes Guidance And Tracking When Performed; Simple	Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review by Carelon.	_		
	Intensity Modulated Radiation Treatment Delivery (Imrt)	MP Criteria: Procedures/services reviewed against Medical			
77386	Includes Guidance And Tracking When Performed: Complex	Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review by Carelon.	_		_
	Guidance For Localization Of Target Volume For Delivery Of	MP Criteria: Procedures/services reviewed against Medical			
77387	Radiation Treatment Includes Intrafraction Tracking When	Policy Criteria. Submit for Recommended Clinical Review to			
	Performed	avoid post-service review by Carelon.	_	_	_
	Unlisted Procedure Medical Radiation Physics Dosimetry	Unlisted: Procedure/service not specifically defined or			
77399	And Treatment Devices And Special Services	classified, maybe subject to contract/clinical review.	_	_	_
	Radiation Treatment Delivery >=1 Mev; Simple	MP Criteria: Procedures/services reviewed against Medical			
77402	,,,,,,,	Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review by Carelon.	_	_	_
	Radiation Treatment Delivery >=1 Mev; Intermediate	MP Criteria: Procedures/services reviewed against Medical			
77407	, , , , , , , , , , , , , , , , , , , ,	Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review by Carelon.	_	_	_
	Radiation Treatment Delivery >=1 Mev; Complex	MP Criteria: Procedures/services reviewed against Medical			
77412		Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review by Carelon.	_	_	_
	Intraoperative Radiation Treatment Delivery X-Ray Single	MP Criteria: Procedures/services reviewed against Medical			
77424	Treatment Session	Policy Criteria. Submit for Recommended Clinical Review to			
	Treatment session	avoid post-service review by Carelon.	_	_	_
	Intraoperative Radiation Treatment Delivery Electrons	MP Criteria: Procedures/services reviewed against Medical			
77425	Single Treatment Session	Policy Criteria. Submit for Recommended Clinical Review to			
77.25	Single Treatment Session	avoid post-service review by Carelon.	_	_	_
	Stereotactic Radiation Treatment Management Of Cranial	MP Criteria: Procedures/services reviewed against Medical			
77432	Lesion(S) (Complete Course Of Treatment Consisting Of 1	Policy Criteria. Submit for Recommended Clinical Review to			
77.132	Session)	avoid post-service review by Carelon.	_	_	_
	Stereotactic Body Radiation Therapy Treatment				
	Management Per Treatment Course To 1 Or More Lesions	MP Criteria: Procedures/services reviewed against Medical			
77435	Including Image Guidance Entire Course Not To Exceed 5	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by Carelon.			
	Fractions Intraoperative Radiation Treatment Management	MP Criteria: Procedures/services reviewed against Medical			
77469	induoperative nadiation freatment management	Policy Criteria. Submit for Recommended Clinical Review to			
,,,,,,,		avoid post-service review by Carelon.	_	-	-
		avoiu post-service review by Cdfeloff.		1	

	Special Treatment Procedure (Eg Total Body Irradiation	MP Criteria: Procedures/services reviewed against Medical			
77470	Hemibody Radiation Per Oral Or Endocavitary Irradiation)	Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review by Carelon.	_		
77400	Unlisted Procedure Therapeutic Radiology Treatment	Unlisted: Procedure/service not specifically defined or			
77499	Management	classified, maybe subject to contract/clinical review.	_	-	-
	Proton Treatment Delivery; Simple Without Compensation	MP Criteria: Procedures/services reviewed against Medical			
77520		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by Carelon.			
	Proton Treatment Delivery; Simple With Compensation	MP Criteria: Procedures/services reviewed against Medical			
77522		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by Carelon.			
	Proton Treatment Delivery; Intermediate	MP Criteria: Procedures/services reviewed against Medical			
77523		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by Carelon.			
	Proton Treatment Delivery; Complex	MP Criteria: Procedures/services reviewed against Medical			
77525		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by Carelon.			
	Infusion Or Instillation Of Radioelement Solution (Includes 3-	MP Criteria: Procedures/services reviewed against Medical			
77750	Month Follow-Up Care)	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by Carelon.			
	Intracavitary Radiation Source Application; Simple	MP Criteria: Procedures/services reviewed against Medical			
77761		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by Carelon.			
	Intracavitary Radiation Source Application; Intermediate	MP Criteria: Procedures/services reviewed against Medical			
77762		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by Carelon.			
	Intracavitary Radiation Source Application; Complex	MP Criteria: Procedures/services reviewed against Medical			
77763		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by Carelon.			
	Remote Afterloading High Dose Rate Radionuclide Skin	MP Criteria: Procedures/services reviewed against Medical			
77767	Surface Brachytherapy Includes Basic Dosimetry When	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Performed; Lesion Diameter Up To 2.0 Cm Or 1 Channel	avoid post-service review by Carelon.			
	Remote Afterloading High Dose Rate Radionuclide Skin	MP Criteria: Procedures/services reviewed against Medical			
77768	Surface Brachytherapy Includes Basic Dosimetry When	Policy Criteria. Submit for Recommended Clinical Review to			
77700	Performed; Lesion Diameter Over 2.0 Cm And 2 Or More	avoid post-service review by Carelon.	_	-	-
	Channels Or Multiple Lesions	<u> </u>			
	Remote Afterloading High Dose Rate Radionuclide	MP Criteria: Procedures/services reviewed against Medical			
77770	Interstitial Or Intracavitary Brachytherapy Includes Basic	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Dosimetry When Performed; 1 Channel	avoid post-service review by Carelon.			
	Remote Afterloading High Dose Rate Radionuclide	MP Criteria: Procedures/services reviewed against Medical			
77771	Interstitial Or Intracavitary Brachytherapy Includes Basic	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Dosimetry When Performed; 2-12 Channels	avoid post-service review by Carelon.			
	Remote Afterloading High Dose Rate Radionuclide	MP Criteria: Procedures/services reviewed against Medical			
77772	Interstitial Or Intracavitary Brachytherapy Includes Basic	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Dosimetry When Performed; Over 12 Channels	avoid post-service review by Carelon.			

	Interstitial Radiation Source Application Complex Includes	MP Criteria: Procedures/services reviewed against Medical			
77778	Supervision Handling Loading Of Radiation Source When	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Performed	avoid post-service review by Carelon.			
	Supervision Handling Loading Of Radiation Source	MP Criteria: Procedures/services reviewed against Medical			
77790		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by Carelon.			
77700	Unlisted Procedure Clinical Brachytherapy	Unlisted: Procedure/service not specifically defined or			
77799		classified, maybe subject to contract/clinical review.	_	-	-
	Thyroid Uptake Single Or Multiple Quantitative	MP Criteria: Procedures/services reviewed against Medical			
78012	Measurement(S) (Including Stimulation Suppression Or	Policy Criteria. Submit for Recommended Clinical Review to			
	Discharge When Performed)	avoid post-service review by BCBS.	_		
	Thyroid Imaging (Including Vascular Flow When	MP Criteria: Procedures/services reviewed against Medical			
78013	Performed);	Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review by BCBS.	_	_	_
	Thyroid Imaging (Including Vascular Flow When	i i			
	Performed); With Single Or Multiple Uptake(S) Quantitative	MP Criteria: Procedures/services reviewed against Medical			
78014	Measurement(S) (Including Stimulation Suppression Or	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Discharge When Performed)	avoid post-service review by BCBS.			
	Thyroid Carcinoma Metastases Imaging; Limited Area (Eg	MP Criteria: Procedures/services reviewed against Medical			
78015	Neck And Chest Only)	Policy Criteria. Submit for Recommended Clinical Review to			
76015	Neck Alla Cliest Olly)	avoid post-service review by BCBS.	-	-	_
	Thyroid Carcinoma Metastases Imaging; With Additional	MP Criteria: Procedures/services reviewed against Medical			
70016		_			
78016	Studies (Eg Urinary Recovery)	Policy Criteria. Submit for Recommended Clinical Review to	_	-	-
	Thursial Cousing and Materiana Investigati Milesta Dedu	avoid post-service review by BCBS. MP Criteria: Procedures/services reviewed against Medical			
70010	Thyroid Carcinoma Metastases Imaging; Whole Body	_			
78018		Policy Criteria. Submit for Recommended Clinical Review to	-	-	-
	The second Consideration Mathematica Harden (1994 Consideration)	avoid post-service review by BCBS.			
	Thyroid Carcinoma Metastases Uptake (List Separately In	MP Criteria: Procedures/services reviewed against Medical			
78020	Addition To Code For Primary Procedure)	Policy Criteria. Submit for Recommended Clinical Review to	_	-	_
		avoid post-service review by BCBS.			
	Parathyroid Planar Imaging (Including Subtraction When	MP Criteria: Procedures/services reviewed against Medical			
78070	Performed);	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by BCBS.			
	Parathyroid Planar Imaging (Including Subtraction When	MP Criteria: Procedures/services reviewed against Medical			
78071	Performed); With Tomographic (Spect)	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by BCBS.			
	Parathyroid Planar Imaging (Including Subtraction When	MP Criteria: Procedures/services reviewed against Medical			
78072	Performed); With Tomographic (Spect) And Concurrently	Policy Criteria. Submit for Recommended Clinical Review to			
70072	Acquired Computed Tomography (Ct) For Anatomical	avoid post-service review by BCBS.	-	-	_
	Localization	avolu post-service review by BCB3.			
	Adrenal Imaging Cortex And/Or Medulla	MP Criteria: Procedures/services reviewed against Medical			
78075		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by BCBS.			
79000	Unlisted Endocrine Procedure Diagnostic Nuclear Medicine	Unlisted: Procedure/service not specifically defined or			
78099		classified, maybe subject to contract/clinical review.	-	-	-

	Bone Marrow Imaging; Limited Area	MP Criteria: Procedures/services reviewed against Medical			
78102		Policy Criteria. Submit for Recommended Clinical Review to		_	_
		avoid post-service review by BCBS.			
	Bone Marrow Imaging; Multiple Areas	MP Criteria: Procedures/services reviewed against Medical			
78103	3 5,	Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review by BCBS.	_	_	_
	Bone Marrow Imaging; Whole Body	MP Criteria: Procedures/services reviewed against Medical			
70104	Bone Marrow imaging; whole Body	·			
78104		Policy Criteria. Submit for Recommended Clinical Review to	-	-	-
		avoid post-service review by BCBS.			
	Spleen Imaging Only With Or Without Vascular Flow	MP Criteria: Procedures/services reviewed against Medical			
78185		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by BCBS.			
	Lymphatics And Lymph Nodes Imaging	MP Criteria: Procedures/services reviewed against Medical			
78195		Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review by BCBS.			
	Unlisted Hematopoietic Reticuloendothelial And Lymphatic				
78199	Procedure Diagnostic Nuclear Medicine	classified, maybe subject to contract/clinical review.	_	_	_
	Liver Imaging; Static Only	MP Criteria: Procedures/services reviewed against Medical			
78201	Liver imaging, Static Only	Policy Criteria. Submit for Recommended Clinical Review to			
/8201		,	_	-	-
		avoid post-service review by BCBS.			
	Liver Imaging; With Vascular Flow	MP Criteria: Procedures/services reviewed against Medical			
78202		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by BCBS.			
	Liver And Spleen Imaging; Static Only	MP Criteria: Procedures/services reviewed against Medical			
78215		Policy Criteria. Submit for Recommended Clinical Review to		_	_
		avoid post-service review by BCBS.			
	Liver And Spleen Imaging; With Vascular Flow	MP Criteria: Procedures/services reviewed against Medical			
78216		Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review by BCBS.	_	_	_
	Hepatobiliary System Imaging Including Gallbladder When	MP Criteria: Procedures/services reviewed against Medical			
78226		Policy Criteria. Submit for Recommended Clinical Review to			
70220	Present;	· ·	_	_	-
		avoid post-service review by BCBS.			
	Hepatobiliary System Imaging Including Gallbladder When	MP Criteria: Procedures/services reviewed against Medical			
78227	Present; With Pharmacologic Intervention Including	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Quantitative Measurement(S) When Performed	avoid post-service review by BCBS.			
	Salivary Gland Imaging;	MP Criteria: Procedures/services reviewed against Medical			
78230		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by BCBS.			
	Salivary Gland Imaging; With Serial Images	MP Criteria: Procedures/services reviewed against Medical			
78231	, , , , , , , , , , , , , , , , , , , ,	Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review by BCBS.	_	_	_
	Salivary Gland Function Study	MP Criteria: Procedures/services reviewed against Medical			
78232	Salivally Gland Lunction Study	·			
/0232		Policy Criteria. Submit for Recommended Clinical Review to	-	-	-
	- 1 122 100	avoid post-service review by BCBS.		-	
	Esophageal Motility	MP Criteria: Procedures/services reviewed against Medical			
78258		Policy Criteria. Submit for Recommended Clinical Review to	-	_	_
		avoid post-service review by BCBS.			

	Gastric Mucosa Imaging	MP Criteria: Procedures/services reviewed against Medical			
78261		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by BCBS.			
	Gastroesophageal Reflux Study	MP Criteria: Procedures/services reviewed against Medical			
78262		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by BCBS.			
	Gastric Emptying Imaging Study (Eg Solid Liquid Or Both);	MP Criteria: Procedures/services reviewed against Medical			
78264		Policy Criteria. Submit for Recommended Clinical Review to	_	_	
		avoid post-service review by BCBS.			
	Gastric Emptying Imaging Study (Eg Solid Liquid Or Both);	MP Criteria: Procedures/services reviewed against Medical			
78265	With Small Bowel Transit	Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review by BCBS.			
	Gastric Emptying Imaging Study (Eg Solid Liquid Or Both);	MP Criteria: Procedures/services reviewed against Medical			
78266	With Small Bowel And Colon Transit Multiple Days	Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review by BCBS.	_	_	_
	Acute Gastrointestinal Blood Loss Imaging	MP Criteria: Procedures/services reviewed against Medical			
78278		Policy Criteria. Submit for Recommended Clinical Review to			
100.0		avoid post-service review by BCBS.	_	_	_
	Intestine Imaging (Eg Ectopic Gastric Mucosa Meckel'S	MP Criteria: Procedures/services reviewed against Medical			
78290	Localization Volvulus)	Policy Criteria. Submit for Recommended Clinical Review to			
70230	Localization volvalus)	avoid post-service review by BCBS.	_	-	-
	Peritoneal-Venous Shunt Patency Test (Eg. For Leveen	MP Criteria: Procedures/services reviewed against Medical			
78291	Denver Shunt)	Policy Criteria. Submit for Recommended Clinical Review to			
70231	Deriver Shuff()	avoid post-service review by BCBS.	-	-	-
	Unlisted Gastrointestinal Procedure Diagnostic Nuclear	Unlisted: Procedure/service not specifically defined or			
78299	Medicine Medicine	classified, maybe subject to contract/clinical review.	_	_	_
	Bone And/Or Joint Imaging; Limited Area	MP Criteria: Procedures/services reviewed against Medical			
78300	Bone And/Or Joint imaging, Limited Area	Policy Criteria. Submit for Recommended Clinical Review to			
76300		avoid post-service review by BCBS.	-	-	-
	Bone And/Or Joint Imaging; Multiple Areas	MP Criteria: Procedures/services reviewed against Medical			
78305	Bone And/Or Joint imaging, Multiple Areas	Policy Criteria. Submit for Recommended Clinical Review to			
78303		l ·	_	_	-
	Dana And On Isiat Imaging Mikala Dadu	avoid post-service review by BCBS. MP Criteria: Procedures/services reviewed against Medical			
78306	Bone And/Or Joint Imaging; Whole Body	-			
78300		Policy Criteria. Submit for Recommended Clinical Review to	-	-	-
	Dana And On Inint Invasion 2 Dhana Ctudu	avoid post-service review by BCBS. MP Criteria: Procedures/services reviewed against Medical			
70245	Bone And/Or Joint Imaging; 3 Phase Study	·			
78315		Policy Criteria. Submit for Recommended Clinical Review to	_	_	-
		avoid post-service review by BCBS.			
78399	Unlisted Musculoskeletal Procedure Diagnostic Nuclear	Unlisted: Procedure/service not specifically defined or			
	Medicine	classified, maybe subject to contract/clinical review.	_		_
	Non-Cardiac Vascular Flow Imaging (le Angiography	MP Criteria: Procedures/services reviewed against Medical			
78445	Venography)	Policy Criteria. Submit for Recommended Clinical Review to	_	_	-
		avoid post-service review by BCBS.			
	Acute Venous Thrombosis Imaging Peptide	MP Criteria: Procedures/services reviewed against Medical			
78456		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by BCBS.			

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	Venous Thrombosis Imaging Venogram; Unilateral	MP Criteria: Procedures/services reviewed against Medical			
78457		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by BCBS.			
	Venous Thrombosis Imaging Venogram; Bilateral	MP Criteria: Procedures/services reviewed against Medical			
78458		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by BCBS.			
70400	Unlisted Cardiovascular Procedure Diagnostic Nuclear	Unlisted: Procedure/service not specifically defined or			
78499	Medicine	classified, maybe subject to contract/clinical review.	_	-	-
	Pulmonary Ventilation Imaging (Eg. Aerosol Or Gas)	MP Criteria: Procedures/services reviewed against Medical			
78579	, , , , , , , , , , , , , , , , , , , ,	Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review by BCBS.	_		_
	Pulmonary Perfusion Imaging (Eg. Particulate)	MP Criteria: Procedures/services reviewed against Medical			
78580	3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3	Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review by BCBS.	_	_	-
	Pulmonary Ventilation (Eg. Aerosol Or Gas) And Perfusion	MP Criteria: Procedures/services reviewed against Medical			
78582	Imaging	Policy Criteria. Submit for Recommended Clinical Review to			
70002	in the same of the	avoid post-service review by BCBS.	_	-	-
	Quantitative Differential Pulmonary Perfusion Including	MP Criteria: Procedures/services reviewed against Medical			
78597	Imaging When Performed	Policy Criteria. Submit for Recommended Clinical Review to			
76557	imaging when renormed	avoid post-service review by BCBS.	-	-	-
	Quantitative Differential Pulmonary Perfusion And	MP Criteria: Procedures/services reviewed against Medical			
70500	·				
78598	Ventilation (Eg Aerosol Or Gas) Including Imaging When	Policy Criteria. Submit for Recommended Clinical Review to	-	-	-
	Performed Provided Pr	avoid post-service review by BCBS.			
78599	Unlisted Respiratory Procedure Diagnostic Nuclear	Unlisted: Procedure/service not specifically defined or			
	Medicine	classified, maybe subject to contract/clinical review.			
	Brain Imaging Less Than 4 Static Views;	MP Criteria: Procedures/services reviewed against Medical			
78600		Policy Criteria. Submit for Recommended Clinical Review to	_	_	-
		avoid post-service review by BCBS.			
	Brain Imaging Less Than 4 Static Views; With Vascular Flow	MP Criteria: Procedures/services reviewed against Medical			
78601		Policy Criteria. Submit for Recommended Clinical Review to	_	_	-
		avoid post-service review by BCBS.			
	Brain Imaging Minimum 4 Static Views;	MP Criteria: Procedures/services reviewed against Medical			
78605		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by BCBS.			
	Brain Imaging Minimum 4 Static Views; With Vascular Flow	MP Criteria: Procedures/services reviewed against Medical			
78606		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by BCBS.			
	Brain Imaging Positron Emission Tomography (Pet);	MP Criteria: Procedures/services reviewed against Medical			
78608	Metabolic Evaluation	Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review by BCBS.			Γ
	Brain Imaging Positron Emission Tomography (Pet);	MP Criteria: Procedures/services reviewed against Medical			
78609	Perfusion Evaluation	Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review by BCBS.	_	_	-
	Brain Imaging Vascular Flow Only	MP Criteria: Procedures/services reviewed against Medical			
78610		Policy Criteria. Submit for Recommended Clinical Review to			
. 5510		avoid post-service review by BCBS.	-	-	-
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	Cerebrospinal Fluid Flow Imaging (Not Including	MP Criteria: Procedures/services reviewed against Medical		
78630	Introduction Of Material); Cisternography	Policy Criteria. Submit for Recommended Clinical Review to _	_	_
		avoid post-service review by BCBS.		
	Cerebrospinal Fluid Flow Imaging (Not Including	MP Criteria: Procedures/services reviewed against Medical		
78635	Introduction Of Material); Ventriculography	Policy Criteria. Submit for Recommended Clinical Review to _		_
		avoid post-service review by BCBS.		
	Cerebrospinal Fluid Flow Imaging (Not Including	MP Criteria: Procedures/services reviewed against Medical		
78645	Introduction Of Material); Shunt Evaluation	Policy Criteria. Submit for Recommended Clinical Review to		_
	"	avoid post-service review by BCBS.		_
	Cerebrospinal Fluid Leakage Detection And Localization	MP Criteria: Procedures/services reviewed against Medical		
78650		Policy Criteria. Submit for Recommended Clinical Review to		
		avoid post-service review by BCBS.	_	_
	Radiopharmaceutical Dacryocystography	MP Criteria: Procedures/services reviewed against Medical		
78660		Policy Criteria. Submit for Recommended Clinical Review to		
		avoid post-service review by BCBS.	_	_
	Unlisted Nervous System Procedure Diagnostic Nuclear	Unlisted: Procedure/service not specifically defined or		
78699	Medicine	classified, maybe subject to contract/clinical review.	_	_
	Kidney Imaging Morphology;	MP Criteria: Procedures/services reviewed against Medical		
78700		Policy Criteria. Submit for Recommended Clinical Review to		
70700		avoid post-service review by BCBS.	_	-
	Kidney Imaging Morphology; With Vascular Flow	MP Criteria: Procedures/services reviewed against Medical		
78701	Mulley imaging Morphology, with vascular now	Policy Criteria. Submit for Recommended Clinical Review to		
78701		avoid post-service review by BCBS.	-	_
	Kidney Imaging Morphology; With Vascular Flow And	MP Criteria: Procedures/services reviewed against Medical		
78707		Policy Criteria. Submit for Recommended Clinical Review to		
76707	Function Single Study Without Pharmacological	·	_	-
	Intervention Kidney Imaging Morphology; With Vascular Flow And	avoid post-service review by BCBS.		
		MP Criteria: Procedures/services reviewed against Medical		
78708	Function Single Study With Pharmacological Intervention	Policy Criteria. Submit for Recommended Clinical Review to _		_
	(Eg Angiotensin Converting Enzyme Inhibitor And/Or	avoid post-service review by BCBS.		
	Diuretic)			
	Kidney Imaging Morphology; With Vascular Flow And	MP Criteria: Procedures/services reviewed against Medical		
78709	Function Multiple Studies With And Without	Policy Criteria. Submit for Recommended Clinical Review to		_
	Pharmacological Intervention (Eg Angiotensin Converting	avoid post-service review by BCBS.		_
	Enzyme Inhibitor And/Or Diuretic)			
70705	Kidney Function Study Non-Imaging Radioisotopic Study	MP Criteria: Procedures/services reviewed against Medical		
78725		Policy Criteria. Submit for Recommended Clinical Review to	_	_
		avoid post-service review by BCBS.		
	Urinary Bladder Residual Study (List Separately In Addition	MP Criteria: Procedures/services reviewed against Medical		
78730	To Code For Primary Procedure)	Policy Criteria. Submit for Recommended Clinical Review to	_	_
		avoid post-service review by BCBS.		
	Ureteral Reflux Study (Radiopharmaceutical Voiding	MP Criteria: Procedures/services reviewed against Medical		
78740	Cystogram)	Policy Criteria. Submit for Recommended Clinical Review to _	_	_
		avoid post-service review by BCBS.		
	Testicular Imaging With Vascular Flow	MP Criteria: Procedures/services reviewed against Medical		
78761		Policy Criteria. Submit for Recommended Clinical Review to _	_	-
		avoid post-service review by BCBS.		

	Unlisted Genitourinary Procedure Diagnostic Nuclear	Unlisted: Procedure/service not specifically defined or			
78799	Medicine	classified, maybe subject to contract/clinical review.	_	-	-
78800	Radiopharmaceutical Localization Of Tumor Inflammatory Process Or Distribution Of Radiopharmaceutical Agent(S) (Includes Vascular Flow And Blood Pool Imaging When Performed); Planar Single Area (Eg Head Neck Chest Pelvis) Single Day Imaging	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS.	-	-	-
78801	Radiopharmaceutical Localization Of Tumor Inflammatory Process Or Distribution Of Radiopharmaceutical Agent(S) (Includes Vascular Flow And Blood Pool Imaging When Performed); Planar 2 Or More Areas (Eg Abdomen And Pelvis Head And Chest) 1 Or More Days Imaging Or Single Area Imaging Over 2 Or More Days	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS.	-	-	-
78802	Radiopharmaceutical Localization Of Tumor Inflammatory Process Or Distribution Of Radiopharmaceutical Agent(S) (Includes Vascular Flow And Blood Pool Imaging When Performed); Planar Whole Body Single Day Imaging	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS.	-	-	-
78803	Radiopharmaceutical Localization Of Tumor Inflammatory Process Or Distribution Of Radiopharmaceutical Agent(S) (Includes Vascular Flow And Blood Pool Imaging When Performed); Tomographic (Spect) Single Area (Eg Head Neck Chest Pelvis) Or Acquisition Single Day Imaging	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS.	-	-	-
78804	Radiopharmaceutical Localization Of Tumor Inflammatory Process Or Distribution Of Radiopharmaceutical Agent(S) (Includes Vascular Flow And Blood Pool Imaging When Performed); Planar Whole Body Requiring 2 Or More Days Imaging	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS.	-	-	-
78811	Positron Emission Tomography (Pet) Imaging; Limited Area (Eg Chest Head/Neck)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS.	-	-	-
78812	Positron Emission Tomography (Pet) Imaging; Skull Base To Mid-Thigh	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS.	-	-	-
78813	Positron Emission Tomography (Pet) Imaging; Whole Body	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS.	-	-	-
78814	Positron Emission Tomography (Pet) With Concurrently Acquired Computed Tomography (Ct) For Attenuation Correction And Anatomical Localization Imaging; Limited Area (Eg Chest Head/Neck)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS.	-	-	-
78815	Positron Emission Tomography (Pet) With Concurrently Acquired Computed Tomography (Ct) For Attenuation Correction And Anatomical Localization Imaging; Skull Base To Mid-Thigh	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS.	-	-	-

78816	Positron Emission Tomography (Pet) With Concurrently Acquired Computed Tomography (Ct) For Attenuation Correction And Anatomical Localization Imaging; Whole	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS.	-	-	-
78830	Body Radiopharmaceutical Localization Of Tumor Inflammatory Process Or Distribution Of Radiopharmaceutical Agent(S) (Includes Vascular Flow And Blood Pool Imaging When Performed); Tomographic (Spect) With Concurrently Acquired Computed Tomography (Ct) Transmission Scan For Anatomical Review Localization And Determination/Detection Of Pathology Single Area (Eg Head Neck Chest Pelvis) Or Acquisition Single Day Imaging	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS.	-	-	-
78831	Radiopharmaceutical Localization Of Tumor Inflammatory Process Or Distribution Of Radiopharmaceutical Agent(S) (Includes Vascular Flow And Blood Pool Imaging When Performed); Tomographic (Spect) Minimum 2 Areas (Eg Pelvis And Knees Chest And Abdomen) Or Separate Acquisitions (Eg Lung Ventilation And Perfusion) Single Day Imaging Or Single Area Or Acquisition Over 2 Or More Days	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS.	-	-	-
78832	Radiopharmaceutical Localization Of Tumor Inflammatory Process Or Distribution Of Radiopharmaceutical Agent(S) (Includes Vascular Flow And Blood Pool Imaging When Performed); Tomographic (Spect) With Concurrently Acquired Computed Tomography (Ct) Transmission Scan For Anatomical Review Localization And Determination/Detection Of Pathology Minimum 2 Areas (Eg Pelvis And Knees Chest And Abdomen) Or Separate Acquisitions (Eg Lung Ventilation And Perfusion) Single Day Imaging Or Single Area Or Acquisition Over 2 Or More Days	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS.	-	-	-
78999	Unlisted Miscellaneous Procedure Diagnostic Nuclear Medicine	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	_	_
79101	Radiopharmaceutical Therapy By Intravenous Administration	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
79403	Radiopharmaceutical Therapy Radiolabeled Monoclonal Antibody By Intravenous Infusion	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_	_
79999	Radiopharmaceutical Therapy Unlisted Procedure	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.		-	
80299	Quantitation Of Therapeutic Drug Not Elsewhere Specified	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-
81099	Unlisted Urinalysis Procedure	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	_	-

	Idh1 (Isocitrate Dehydrogenase 1 [Nadp+] Soluble) (Eg	MP Criteria: Procedures/services reviewed against Medical			
81120	Glioma) Common Variants (Eg R132H R132C)	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by BCBS.			
	Idh2 (Isocitrate Dehydrogenase 2 [Nadp+] Mitochondrial)	MP Criteria: Procedures/services reviewed against Medical			
81121	(Eg Glioma) Common Variants (Eg R140W R172M)	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by BCBS.			
	Brca1 (Brca1 Dna Repair Associated) Brca2 (Brca2 Dna				
	Repair Associated) (Eg Hereditary Breast And Ovarian	MP Criteria: Procedures/services reviewed against Medical			
81162	Cancer) Gene Analysis; Full Sequence Analysis And Full	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Duplication/Deletion Analysis (le Detection Of Large Gene	avoid post-service review by BCBS.			
	Rearrangements)				
	Brca1 (Brca1 Dna Repair Associated) Brca2 (Brca2 Dna	MP Criteria: Procedures/services reviewed against Medical			
81163	Repair Associated) (Eg Hereditary Breast And Ovarian	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Cancer) Gene Analysis; Full Sequence Analysis	avoid post-service review by Carelon.			
	Brca1 (Brca1 Dna Repair Associated) Brca2 (Brca2 Dna	MP Criteria: Procedures/services reviewed against Medical			
81164	Repair Associated) (Eg Hereditary Breast And Ovarian	Policy Criteria. Submit for Recommended Clinical Review to			
81104	Cancer) Gene Analysis; Full Duplication/Deletion Analysis (le	avoid post-service review by Carelon.	_	-	_
	Detection Of Large Gene Rearrangements)	avoid post-service review by Careion.			
	Brca1 (Brca1 Dna Repair Associated) (Eg Hereditary Breast	MP Criteria: Procedures/services reviewed against Medical			
81165	And Ovarian Cancer) Gene Analysis; Full Sequence Analysis	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by Carelon.			
	Brca1 (Brca1 Dna Repair Associated) (Eg Hereditary Breast	MP Criteria: Procedures/services reviewed against Medical			
81166	And Ovarian Cancer) Gene Analysis; Full	Policy Criteria. Submit for Recommended Clinical Review to			
81100	Duplication/Deletion Analysis (le Detection Of Large Gene	avoid post-service review by Carelon.	_	-	_
	Rearrangements)	avoid post-service review by Careion.			
	Brca2 (Brca2 Dna Repair Associated) (Eg Hereditary Breast	MP Criteria: Procedures/services reviewed against Medical			
81167	And Ovarian Cancer) Gene Analysis; Full	Policy Criteria. Submit for Recommended Clinical Review to			
01107	Duplication/Deletion Analysis (le Detection Of Large Gene	avoid post-service review by Carelon.	-	-	-
	Rearrangements)	· ·			
	Ccnd1/lgh (T(11;14)) (Eg Mantle Cell Lymphoma)	MP Criteria: Procedures/services reviewed against Medical			
81168	Translocation Analysis Major Breakpoint Qualitative And	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Quantitative If Performed	avoid post-service review by Carelon.			
	Abl1 (Abl Proto-Oncogene 1 Non-Receptor Tyrosine Kinase)	MP Criteria: Procedures/services reviewed against Medical			
81170	(Eg Acquired Imatinib Tyrosine Kinase Inhibitor Resistance)	Policy Criteria. Submit for Recommended Clinical Review to			
01170	Gene Analysis Variants In The Kinase Domain	avoid post-service review by Carelon.	-	-	-
		, ,			
	Aff2 (Alf Transcription Elongation Factor 2 [Fmr2]) (Eg	MP Criteria: Procedures/services reviewed against Medical			
81171	Fragile X Intellectual Disability 2 [Fraxe]) Gene Analysis;	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Evaluation To Detect Abnormal (Eg Expanded) Alleles	avoid post-service review by Carelon.			
	Aff2 (Alf Transcription Elongation Factor 2 [Fmr2]) (Eg	MP Criteria: Procedures/services reviewed against Medical			
81172	Fragile X Intellectual Disability 2 [Fraxe]) Gene Analysis;	Policy Criteria. Submit for Recommended Clinical Review to			
011/2	Characterization Of Alleles (Eg Expanded Size And	avoid post-service review by Carelon.	-	-	-
	Methylation Status)	, ,			
	Ar (Androgen Receptor) (Eg Spinal And Bulbar Muscular	MP Criteria: Procedures/services reviewed against Medical			
81173	Atrophy Kennedy Disease X Chromosome Inactivation)	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Gene Analysis; Full Gene Sequence	avoid post-service review by Carelon.			

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	Ar (Androgen Receptor) (Eg Spinal And Bulbar Muscular	MP Criteria: Procedures/services reviewed against Medical			
81174	Atrophy Kennedy Disease X Chromosome Inactivation)	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Gene Analysis; Known Familial Variant	avoid post-service review by Carelon.			
	Asxl1 (Additional Sex Combs Like 1 Transcriptional	MP Criteria: Procedures/services reviewed against Medical			
81175	Regulator) (Eg Myelodysplastic Syndrome	Policy Criteria. Submit for Recommended Clinical Review to			
011/3	Myeloproliferative Neoplasms Chronic Myelomonocytic	avoid post-service review by Carelon.	-	-	-
	Leukemia) Gene Analysis; Full Gene Sequence	avoid post-service review by Careion.			
	Asxl1 (Additional Sex Combs Like 1 Transcriptional				
	Regulator) (Eg Myelodysplastic Syndrome	MP Criteria: Procedures/services reviewed against Medical			
81176	Myeloproliferative Neoplasms Chronic Myelomonocytic	Policy Criteria. Submit for Recommended Clinical Review to	_		
	Leukemia) Gene Analysis; Targeted Sequence Analysis (Eg	avoid post-service review by Carelon.			
	Exon 12)	,			
	Atn1 (Atrophin 1) (Eg Dentatorubral-Pallidoluysian Atrophy)	MP Criteria: Procedures/services reviewed against Medical			
81177	Gene Analysis Evaluation To Detect Abnormal (Eg	Policy Criteria. Submit for Recommended Clinical Review to			
	Expanded) Alleles	avoid post-service review by Carelon.	_	_	_
	Atxn1 (Ataxin 1) (Eg Spinocerebellar Ataxia) Gene Analysis	MP Criteria: Procedures/services reviewed against Medical			
81178	Evaluation To Detect Abnormal (Eg Expanded) Alleles	Policy Criteria. Submit for Recommended Clinical Review to			
01170	Evaluation to Detect April mar (Eg Expanded) Ancies	avoid post-service review by Carelon.	_	-	-
	Atxn2 (Ataxin 2) (Eg Spinocerebellar Ataxia) Gene Analysis	MP Criteria: Procedures/services reviewed against Medical			
81179	Evaluation To Detect Abnormal (Eg. Expanded) Alleles	Policy Criteria. Submit for Recommended Clinical Review to			
01175	Evaluation to Detect Abnormal (Lg Expanded) Alleles	avoid post-service review by Carelon.	-	-	_
	Atxn3 (Ataxin 3) (Eg Spinocerebellar Ataxia Machado-	MP Criteria: Procedures/services reviewed against Medical			
81180	Joseph Disease) Gene Analysis Evaluation To Detect	Policy Criteria. Submit for Recommended Clinical Review to			
01100		· ·	-	-	-
	Abnormal (Eg Expanded) Alleles	avoid post-service review by Carelon. MP Criteria: Procedures/services reviewed against Medical			
81181	Atxn7 (Ataxin 7) (Eg Spinocerebellar Ataxia) Gene Analysis	<u>-</u>			
91191	Evaluation To Detect Abnormal (Eg Expanded) Alleles	Policy Criteria. Submit for Recommended Clinical Review to	-	-	-
	At a CO a /At a CO a constitution of the annual fall of the Constitution of the Consti	avoid post-service review by Carelon.			
04400	Atxn8Os (Atxn8 Opposite Strand [Non-Protein Coding]) (Eg	MP Criteria: Procedures/services reviewed against Medical			
81182	Spinocerebellar Ataxia) Gene Analysis Evaluation To Detect	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Abnormal (Eg Expanded) Alleles	avoid post-service review by Carelon.			
	Atxn10 (Ataxin 10) (Eg Spinocerebellar Ataxia) Gene	MP Criteria: Procedures/services reviewed against Medical			
81183	Analysis Evaluation To Detect Abnormal (Eg Expanded)	Policy Criteria. Submit for Recommended Clinical Review to	-	-	_
	Alleles	avoid post-service review by Carelon.			
	Cacna1A (Calcium Voltage-Gated Channel Subunit Alpha1 A)				
81184	(Eg Spinocerebellar Ataxia) Gene Analysis; Evaluation To	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Detect Abnormal (Eg Expanded) Alleles	avoid post-service review by Carelon.			
	Cacna1A (Calcium Voltage-Gated Channel Subunit Alpha1 A)				
81185	(Eg Spinocerebellar Ataxia) Gene Analysis; Full Gene	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Sequence	avoid post-service review by Carelon.			
	Cacna1A (Calcium Voltage-Gated Channel Subunit Alpha1 A)	MP Criteria: Procedures/services reviewed against Medical			
81186	(Eg Spinocerebellar Ataxia) Gene Analysis; Known Familial	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Variant	avoid post-service review by Carelon.			
	Cnbp (Cchc-Type Zinc Finger Nucleic Acid Binding Protein)	MP Criteria: Procedures/services reviewed against Medical			
81187	(Eg Myotonic Dystrophy Type 2) Gene Analysis Evaluation	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	To Detect Abnormal (Eg Expanded) Alleles	avoid post-service review by Carelon.			

	Cstb (Cystatin B) (Eg Unverricht-Lundborg Disease) Gene	MP Criteria: Procedures/services reviewed against Medical			
81188	Analysis; Evaluation To Detect Abnormal (Eg Expanded)	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Alleles	avoid post-service review by Carelon.			
	Cstb (Cystatin B) (Eg Unverricht-Lundborg Disease) Gene	MP Criteria: Procedures/services reviewed against Medical			
81189	Analysis; Full Gene Sequence	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by Carelon.			
	Cstb (Cystatin B) (Eg Unverricht-Lundborg Disease) Gene	MP Criteria: Procedures/services reviewed against Medical			
81190	Analysis; Known Familial Variant(S)	Policy Criteria. Submit for Recommended Clinical Review to	_		
		avoid post-service review by Carelon.			
	Ntrk1 (Neurotrophic Receptor Tyrosine Kinase 1) (Eg Solid	MP Criteria: Procedures/services reviewed against Medical			
81191	Tumors) Translocation Analysis	Policy Criteria. Submit for Recommended Clinical Review to	_		_
		avoid post-service review by Carelon.			
	Ntrk2 (Neurotrophic Receptor Tyrosine Kinase 2) (Eg Solid	MP Criteria: Procedures/services reviewed against Medical			
81192	Tumors) Translocation Analysis	Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review by Carelon.	_		
	Ntrk3 (Neurotrophic Receptor Tyrosine Kinase 3) (Eg Solid	MP Criteria: Procedures/services reviewed against Medical			
81193	Tumors) Translocation Analysis	Policy Criteria. Submit for Recommended Clinical Review to			
	, , , , , , , , , , , , , , , , , , , ,	avoid post-service review by Carelon.	-	_	
	Ntrk (Neurotrophic Receptor Tyrosine Kinase 1 2 And 3) (Eg				
81194	Solid Tumors) Translocation Analysis	Policy Criteria. Submit for Recommended Clinical Review to			
	,	avoid post-service review by Carelon.	_	_	_
	Aspa (Aspartoacylase) (Eg Canavan Disease) Gene Analysis	MP Criteria: Procedures/services reviewed against Medical			
81200	Common Variants (Eg E285A Y231X)	Policy Criteria. Submit for Recommended Clinical Review to			
	335 (2g 2233) (232.)	avoid post-service review by Carelon.	_	_	_
	Apc (Adenomatous Polyposis Coli) (Eg Familial	MP Criteria: Procedures/services reviewed against Medical			
81201	Adenomatosis Polyposis [Fap] Attenuated Fap) Gene	Policy Criteria. Submit for Recommended Clinical Review to			
	Analysis; Full Gene Sequence	avoid post-service review by Carelon.	_	_	_
	Apc (Adenomatous Polyposis Coli) (Eg Familial	MP Criteria: Procedures/services reviewed against Medical			
81202	Adenomatosis Polyposis [Fap] Attenuated Fap) Gene	Policy Criteria. Submit for Recommended Clinical Review to			
	Analysis; Known Familial Variants	avoid post-service review by Carelon.	_	_	_
	Apc (Adenomatous Polyposis Coli) (Eg Familial	MP Criteria: Procedures/services reviewed against Medical			
81203	Adenomatosis Polyposis [Fap] Attenuated Fap) Gene	Policy Criteria. Submit for Recommended Clinical Review to			
01200	Analysis; Duplication/Deletion Variants	avoid post-service review by Carelon.	_	_	_
	Ar (Androgen Receptor) (Eg. Spinal And Bulbar Muscular				
	Atrophy Kennedy Disease X Chromosome Inactivation)	MP Criteria: Procedures/services reviewed against Medical			
81204	Gene Analysis; Characterization Of Alleles (Eg Expanded Size	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Or Methylation Status)	avoid post-service review by Carelon.			
	Bckdhb (Branched-Chain Keto Acid Dehydrogenase E1 Beta	MP Criteria: Procedures/services reviewed against Medical			
81205	Polypeptide) (Eg Maple Syrup Urine Disease) Gene Analysis	Policy Criteria. Submit for Recommended Clinical Review to			
01203	Common Variants (Eg. R183P G278S E422X)	avoid post-service review by Carelon.	-	-	-
	Bcr/Abl1 (T(9;22)) (Eg Chronic Myelogenous Leukemia)	MP Criteria: Procedures/services reviewed against Medical			
81208	Translocation Analysis; Other Breakpoint Qualitative Or	Policy Criteria. Submit for Recommended Clinical Review to			
01200	Quantitative	avoid post-service review by Carelon.	_	-	-
	Blm (Bloom Syndrome Recq Helicase-Like) (Eg Bloom	MP Criteria: Procedures/services reviewed against Medical			
81209	, , , , , , , , , , , , , , , , , , , ,	Policy Criteria. Submit for Recommended Clinical Review to			
01703	Syndrome) Gene Analysis 2281Del6Ins7 Variant	•	_	-	-
		avoid post-service review by Carelon.			1

	Braf (B-Raf Proto-Oncogene Serine/Threonine Kinase) (Eg	MP Criteria: Procedures/services reviewed against Medical			
81210	Colon Cancer Melanoma) Gene Analysis V600 Variant(S)	Policy Criteria. Submit for Recommended Clinical Review to			
01210	Colon cancer inclanding, denerality is vood variant(s)	avoid post-service review by Carelon.	_	_	-
	Brca1 (Brca1 Dna Repair Associated) Brca2 (Brca2 Dna				
04040	Repair Associated) (Eg Hereditary Breast And Ovarian	MP Criteria: Procedures/services reviewed against Medical			
81212	Cancer) Gene Analysis; 185Delag 5385Insc 6174Delt	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Variants	avoid post-service review by Carelon.			
	Brca1 (Brca1 Dna Repair Associated) (Eg Hereditary Breast	MP Criteria: Procedures/services reviewed against Medical			
81215	And Ovarian Cancer) Gene Analysis; Known Familial Variant	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by Carelon.			
	Brca2 (Brca2 Dna Repair Associated) (Eg Hereditary Breast	MP Criteria: Procedures/services reviewed against Medical			
81216	And Ovarian Cancer) Gene Analysis; Full Sequence Analysis	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by Carelon.			
	Brca2 (Brca2 Dna Repair Associated) (Eg Hereditary Breast	MP Criteria: Procedures/services reviewed against Medical			
81217	And Ovarian Cancer) Gene Analysis; Known Familial Variant	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by Carelon.			
	Cebpa (Ccaat/Enhancer Binding Protein [C/Ebp] Alpha) (Eg	MP Criteria: Procedures/services reviewed against Medical			
81218	Acute Myeloid Leukemia) Gene Analysis Full Gene	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Sequence	avoid post-service review by Carelon.			
	Calr (Calreticulin) (Eg Myeloproliferative Disorders) Gene	MP Criteria: Procedures/services reviewed against Medical			
81219	Analysis Common Variants In Exon 9	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by Carelon.			
	Cftr (Cystic Fibrosis Transmembrane Conductance Regulator)				
81221	(Eg Cystic Fibrosis) Gene Analysis; Known Familial Variants	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by Carelon.			
	Cftr (Cystic Fibrosis Transmembrane Conductance Regulator)				
81222	(Eg Cystic Fibrosis) Gene Analysis; Duplication/Deletion	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Variants	avoid post-service review by Carelon.			
	Cftr (Cystic Fibrosis Transmembrane Conductance Regulator)				
81223	(Eg Cystic Fibrosis) Gene Analysis; Full Gene Sequence	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by Carelon.			
	Cftr (Cystic Fibrosis Transmembrane Conductance Regulator)				
81224	(Eg Cystic Fibrosis) Gene Analysis; Intron 8 Poly-T Analysis	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	(Eg Male Infertility)	avoid post-service review by Carelon.			
	Cyp2C19 (Cytochrome P450 Family 2 Subfamily C	MP Criteria: Procedures/services reviewed against Medical			
81225	Polypeptide 19) (Eg Drug Metabolism) Gene Analysis	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Common Variants (Eg *2 *3 *4 *8 *17)	avoid post-service review by Carelon.			
	Cyp2D6 (Cytochrome P450 Family 2 Subfamily D	MP Criteria: Procedures/services reviewed against Medical			
81226	Polypeptide 6) (Eg Drug Metabolism) Gene Analysis	Policy Criteria. Submit for Recommended Clinical Review to			
	Common Variants (Eg *2 *3 *4 *5 *6 *9 *10 *17 *19	avoid post-service review by Carelon.	-	-	-
	*29 *35 *41 *1Xn *2Xn *4Xn)	, i			
	Cyp2C9 (Cytochrome P450 Family 2 Subfamily C	MP Criteria: Procedures/services reviewed against Medical			
81227	Polypeptide 9) (Eg Drug Metabolism) Gene Analysis	Policy Criteria. Submit for Recommended Clinical Review to	_	_	-
	Common Variants (Eg *2 *3 *5 *6)	avoid post-service review by Carelon.			

	Cytogenomic (Genome-Wide) Analysis For Constitutional	MP Criteria: Procedures/services reviewed against Medical			
	Chromosomal Abnormalities; Interrogation Of Genomic	·			
81228	Regions For Copy Number Variants Comparative Genomic	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by Carelon.			
	Hybridization [Cgh] Microarray Analysis				
	Cytogenomic (Genome-Wide) Analysis For Constitutional				
	Chromosomal Abnormalities; Interrogation Of Genomic	MP Criteria: Procedures/services reviewed against Medical			
81229	Regions For Copy Number And Single Nucleotide	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Polymorphism (Snp) Variants Comparative Genomic	avoid post-service review by Carelon.			
	Hybridization (Cgh) Microarray Analysis	· ·			
		MP Criteria: Procedures/services reviewed against Medical			
81230	(Eg Drug Metabolism) Gene Analysis Common Variant(S)	Policy Criteria. Submit for Recommended Clinical Review to			
81230	, , , , , , , , , , , , , , , , , , , ,	·	_	-	_
	(Eg *2 *22)	avoid post-service review by Carelon.			
		MP Criteria: Procedures/services reviewed against Medical			
81231	(Eg Drug Metabolism) Gene Analysis Common Variants (Eg	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	*2 *3 *4 *5 *6 *7)	avoid post-service review by Carelon.			
	Dpyd (Dihydropyrimidine Dehydrogenase) (Eg 5-	MP Criteria: Procedures/services reviewed against Medical			
81232	Fluorouracil/5-Fu And Capecitabine Drug Metabolism) Gene	Policy Criteria. Submit for Recommended Clinical Review to			
	Analysis Common Variant(S) (Eg *2A *4 *5 *6)	avoid post-service review by Carelon.	_	<u> </u>	-
	Btk (Bruton'S Tyrosine Kinase) (Eg Chronic Lymphocytic	MP Criteria: Procedures/services reviewed against Medical			
81233	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Policy Criteria. Submit for Recommended Clinical Review to			
81233	Leukemia) Gene Analysis Common Variants (Eg C481S	·	_	-	_
	C481R C481F)	avoid post-service review by Carelon.			
	, , , , , , , , , , , , , , , , , , , ,	MP Criteria: Procedures/services reviewed against Medical			
81234	Gene Analysis; Evaluation To Detect Abnormal (Expanded)	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Alleles	avoid post-service review by Carelon.			
	Egfr (Epidermal Growth Factor Receptor) (Eg Non-Small Cell	MD Citation Deposit and the state of the sta			
	Lung Cancer) Gene Analysis Common Variants (Eg Exon 19	MP Criteria: Procedures/services reviewed against Medical			
81235	Lrea Deletion L858R T790M G719A G719S L861Q)	Policy Criteria. Submit for Recommended Clinical Review to	_	_	
	Ered Deletion Loson 1750M G715A G7155 Looldy	avoid post-service review by Carelon.			
	Ezh2 (Enhancer Of Zeste 2 Polycomb Repressive Complex 2				
	· · · · · · · · · · · · · · · · · · ·	MP Criteria: Procedures/services reviewed against Medical			
81236	Subunit) (Eg Myelodysplastic Syndrome Myeloproliferative	Policy Criteria. Submit for Recommended Clinical Review to	_	L	_
	Neoplasms) Gene Analysis Full Gene Sequence	avoid post-service review by Carelon.			
	Ezh2 (Enhancer Of Zeste 2 Polycomb Repressive Complex 2	MP Criteria: Procedures/services reviewed against Medical			
81237	Subunit) (Eg Diffuse Large B-Cell Lymphoma) Gene Analysis	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Common Variant(S) (Eg Codon 646)	avoid post-service review by Carelon.			
	F9 (Coagulation Factor Ix) (Eg Hemophilia B) Full Gene	MP Criteria: Procedures/services reviewed against Medical			
81238	Sequence	Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review by Carelon.	_	<u> </u>	_
	Dmpk (Dm1 Protein Kinase) (Eg Myotonic Dystrophy Type 1)	·			
01220		_			
81239	Gene Analysis; Characterization Of Alleles (Eg Expanded	Policy Criteria. Submit for Recommended Clinical Review to	_	-	_
	Size)	avoid post-service review by Carelon.			
	F2 (Prothrombin Coagulation Factor Ii) (Eg Hereditary	MP Criteria: Procedures/services reviewed against Medical			
81240	Hypercoagulability) Gene Analysis 20210G>A Variant	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by Carelon.			
	Fancc (Fanconi Anemia Complementation Group C) (Eg	MP Criteria: Procedures/services reviewed against Medical			
81242	Fanconi Anemia Type C) Gene Analysis Common Variant	Policy Criteria. Submit for Recommended Clinical Review to			
· · · =	(Eg Ivs4+4A>T)	avoid post-service review by Carelon.	_	-	-
	[[LK 183474A/1]	avoia post service review by careion.			

	Fmr1 (Fragile X Messenger Ribonucleoprotein 1) (Eg Fragile	MP Criteria: Procedures/services reviewed against Medical			
01244	X Syndrome X-Linked Intellectual Disability [Xlid]) Gene	Policy Criteria. Submit for Recommended Clinical Review to			
81244	Analysis; Characterization Of Alleles (Eg Expanded Size And	·	_	-	-
	Promoter Methylation Status)	avoid post-service review by Carelon.			
	Flt3 (Fms-Related Tyrosine Kinase 3) (Eg. Acute Myeloid	MP Criteria: Procedures/services reviewed against Medical			
81245	Leukemia) Gene Analysis; Internal Tandem Duplication (Itd)	Policy Criteria. Submit for Recommended Clinical Review to			
012.0	Variants (le Exons 14 15)	avoid post-service review by Carelon.	_	_	-
	Flt3 (Fms-Related Tyrosine Kinase 3) (Eg. Acute Myeloid	MP Criteria: Procedures/services reviewed against Medical			
81246	1 1 1	Policy Criteria. Submit for Recommended Clinical Review to			
81240	Leukemia) Gene Analysis; Tyrosine Kinase Domain (Tkd)	·	_	-	-
	Variants (Eg D835 1836)	avoid post-service review by Carelon.			
	G6Pd (Glucose-6-Phosphate Dehydrogenase) (Eg Hemolytic				
81247		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	A-)	avoid post-service review by Carelon.			
	G6Pd (Glucose-6-Phosphate Dehydrogenase) (Eg Hemolytic	MP Criteria: Procedures/services reviewed against Medical			
81248	Anemia Jaundice) Gene Analysis; Known Familial Variant(S)	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by Carelon.			
	G6Pd (Glucose-6-Phosphate Dehydrogenase) (Eg Hemolytic	MP Criteria: Procedures/services reviewed against Medical			
81249	Anemia Jaundice) Gene Analysis; Full Gene Sequence	Policy Criteria. Submit for Recommended Clinical Review to			
	,	avoid post-service review by Carelon.	_	_	_
	G6Pc (Glucose-6-Phosphatase Catalytic Subunit) (Eg	MP Criteria: Procedures/services reviewed against Medical			
81250	Glycogen Storage Disease Type 1A Von Gierke Disease)	Policy Criteria. Submit for Recommended Clinical Review to			
81230		·	_	-	-
	Gene Analysis Common Variants (Eg. R83C Q347X)	avoid post-service review by Carelon.			
04054	Gba (Glucosidase Beta Acid) (Eg Gaucher Disease) Gene	MP Criteria: Procedures/services reviewed against Medical			
81251	Analysis Common Variants (Eg N370S 84Gg L444P	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	lvs2+1G>A)	avoid post-service review by Carelon.			
	Gjb2 (Gap Junction Protein Beta 2 26Kda Connexin 26) (Eg	_			
81252	Nonsyndromic Hearing Loss) Gene Analysis; Full Gene	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Sequence	avoid post-service review by Carelon.			
	Gjb2 (Gap Junction Protein Beta 2 26Kda Connexin 26) (Eg	MP Criteria: Procedures/services reviewed against Medical			
81253	Nonsyndromic Hearing Loss) Gene Analysis; Known Familial	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Variants	avoid post-service review by Carelon.			
	Gjb6 (Gap Junction Protein Beta 6 30Kda Connexin 30) (Eg				
	Nonsyndromic Hearing Loss) Gene Analysis Common	MP Criteria: Procedures/services reviewed against Medical			
81254	Variants (Eg 309Kb [Del(Gjb6-D13S1830)] And 232Kb	Policy Criteria. Submit for Recommended Clinical Review to	-	_	-
	[Del(Gib6-D13S1854)])	avoid post-service review by Carelon.			
	Hexa (Hexosaminidase A [Alpha Polypeptide]) (Eg Tay-Sachs	MP Criteria: Procedures/services reviewed against Medical			
81255	Disease) Gene Analysis Common Variants (Eg. 1278Instatc	Policy Criteria. Submit for Recommended Clinical Review to			
81233	, ,	·	_	-	-
	1421+1G>C G269S)	avoid post-service review by Carelon.			
	Hfe (Hemochromatosis) (Eg Hereditary Hemochromatosis)	MP Criteria: Procedures/services reviewed against Medical			
81256	Gene Analysis Common Variants (Eg C282Y H63D)	Policy Criteria. Submit for Recommended Clinical Review to	_	_	-
		avoid post-service review by Carelon.			
	Hba1/Hba2 (Alpha Globin 1 And Alpha Globin 2) (Eg Alpha				
	Thalassemia Hb Bart Hydrops Fetalis Syndrome Hbh	MP Criteria: Procedures/services reviewed against Medical			
01257	Disease) Gene Analysis; Common Deletions Or Variant (Eg	·			
81257	Southeast Asian Thai Filipino Mediterranean Alpha3.7	Policy Criteria. Submit for Recommended Clinical Review to	_	-	-
	Alpha4.2 Alpha20.5 Constant Spring)	avoid post-service review by Carelon.			
	The second constant spring				

	Hba1/Hba2 (Alpha Globin 1 And Alpha Globin 2) (Eg Alpha	MP Criteria: Procedures/services reviewed against Medical			
81258	Thalassemia Hb Bart Hydrops Fetalis Syndrome Hbh	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Disease) Gene Analysis; Known Familial Variant	avoid post-service review by Carelon.			
	Hba1/Hba2 (Alpha Globin 1 And Alpha Globin 2) (Eg Alpha	MP Criteria: Procedures/services reviewed against Medical			
81259	Thalassemia Hb Bart Hydrops Fetalis Syndrome Hbh	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Disease) Gene Analysis; Full Gene Sequence	avoid post-service review by Carelon.			
	Ikbkap (Inhibitor Of Kappa Light Polypeptide Gene Enhancer	MP Criteria: Procedures/services reviewed against Medical			
81260	In B-Cells Kinase Complex-Associated Protein) (Eg Familial	Policy Criteria. Submit for Recommended Clinical Review to			
	Dysautonomia) Gene Analysis Common Variants (Eg	avoid post-service review by Carelon.	_	_	_
	2507+6T>C R696P)				
	Igh@ (Immunoglobulin Heavy Chain Locus) (Eg Leukemias	MP Criteria: Procedures/services reviewed against Medical			
81261	And Lymphomas B-Cell) Gene Rearrangement Analysis To	Policy Criteria. Submit for Recommended Clinical Review to			
	Detect Abnormal Clonal Population(S); Amplified	avoid post-service review by Carelon.	_	_	_
	Methodology (Eg Polymerase Chain Reaction)				
	Igh@ (Immunoglobulin Heavy Chain Locus) (Eg Leukemias	MP Criteria: Procedures/services reviewed against Medical			
81262	And Lymphomas B-Cell) Gene Rearrangement Analysis To	Policy Criteria. Submit for Recommended Clinical Review to			
	Detect Abnormal Clonal Population(S); Direct Probe	avoid post-service review by Carelon.	_	_	_
	Methodology (Eg Southern Blot)				
	Igh@ (Immunoglobulin Heavy Chain Locus) (Eg Leukemia	MP Criteria: Procedures/services reviewed against Medical			
81263	And Lymphoma B-Cell) Variable Region Somatic Mutation	Policy Criteria. Submit for Recommended Clinical Review to	_	_	-
	Analysis	avoid post-service review by Carelon.			
	Igk@ (Immunoglobulin Kappa Light Chain Locus) (Eg	MP Criteria: Procedures/services reviewed against Medical			
81264	Leukemia And Lymphoma B-Cell) Gene Rearrangement	Policy Criteria. Submit for Recommended Clinical Review to			
	Analysis Evaluation To Detect Abnormal Clonal	avoid post-service review by Carelon.	_		
	Population(S)	,			
	Comparative Analysis Using Short Tandem Repeat (Str)				
	Markers; Patient And Comparative Specimen (Eg Pre-	NAD Criteria: Dragodures/comises reviewed acciret Nacdicel			
04265	Transplant Recipient And Donor Germline Testing Post-	MP Criteria: Procedures/services reviewed against Medical			
81265	Transplant Non-Hematopoietic Recipient Germline [Eg	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Buccal Swab Or Other Germline Tissue Sample] And Donor	avoid post-service review by Carelon.			
	Testing Twin Zygosity Testing Or Maternal Cell				
	Contamination Of Fetal Cells)				
	Comparative Analysis Using Short Tandem Repeat (Str)				
	Markers; Each Additional Specimen (Eg Additional Cord	MP Criteria: Procedures/services reviewed against Medical			
81266	Blood Donor Additional Fetal Samples From Different	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Cultures Or Additional Zygosity In Multiple Birth	avoid post-service review by Carelon.			
	Pregnancies) (List Separately In Addition To Code For				
	Primary Procedure) Hba1/Hba2 (Alpha Globin 1 And Alpha Globin 2) (Eg Alpha			+	
		MP Criteria: Procedures/services reviewed against Medical			
81269	Thalassemia Hb Bart Hydrops Fetalis Syndrome Hbh	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Disease) Gene Analysis; Duplication/Deletion Variants	avoid post-service review by Carelon.			
	Jak2 (Janus Kinase 2) (Eg Myeloproliferative Disorder) Gene	MP Criteria: Procedures/services reviewed against Medical			
81270	Analysis P.Val617Phe (V617F) Variant	Policy Criteria. Submit for Recommended Clinical Review to			
	7.1.1.2.7.5.5 1 1 valuari 110 (vozri) valuari	avoid post-service review by Carelon.	-	_	_
		avoid post service review by curcion.	I		1

	Htt (Huntingtin) (Eg Huntington Disease) Gene Analysis;	MP Criteria: Procedures/services reviewed against Medical			
81271	Evaluation To Detect Abnormal (Eg Expanded) Alleles	Policy Criteria. Submit for Recommended Clinical Review to			
01271	Evaluation to Detect Abnormal (Eg. Expanded) Alleles	avoid post-service review by Carelon.	-	-	-
	Kit (V-Kit Hardy-Zuckerman 4 Feline Sarcoma Viral Oncogene				
	Homolog) (Eg Gastrointestinal Stromal Tumor [Gist] Acute	MP Criteria: Procedures/services reviewed against Medical			
81272		Policy Criteria. Submit for Recommended Clinical Review to			
012/2	Myeloid Leukemia Melanoma) Gene Analysis Targeted	avoid post-service review by Carelon.	_	_	-
	Sequence Analysis (Eg Exons 8 11 13 17 18)	avolu post-service review by Careion.			
	Kit (V-Kit Hardy-Zuckerman 4 Feline Sarcoma Viral Oncogene				
81273	Homolog) (Eg Mastocytosis) Gene Analysis D816 Variant(S)		_	_	_
		avoid post-service review by Carelon.			
	Htt (Huntingtin) (Eg Huntington Disease) Gene Analysis;	MP Criteria: Procedures/services reviewed against Medical			
81274	Characterization Of Alleles (Eg Expanded Size)	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by Carelon.			
	Kras (Kirsten Rat Sarcoma Viral Oncogene Homolog) (Eg	MP Criteria: Procedures/services reviewed against Medical			
81275	Carcinoma) Gene Analysis; Variants In Exon 2 (Eg Codons 12	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	And 13)	avoid post-service review by Carelon.			
	Kras (Kirsten Rat Sarcoma Viral Oncogene Homolog) (Eg	MP Criteria: Procedures/services reviewed against Medical			
81276	Carcinoma) Gene Analysis; Additional Variant(S) (Eg Codon	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	61 Codon 146)	avoid post-service review by Carelon.			
	Cytogenomic Neoplasia (Genome-Wide) Microarray Analysis	MP Criteria: Procedures/services reviewed against Medical			
01277	Interrogation Of Genomic Regions For Copy Number And	·			
81277	Loss-Of-Heterozygosity Variants For Chromosomal	Policy Criteria. Submit for Recommended Clinical Review to	-	-	-
	Abnormalities	avoid post-service review by Carelon.			
	Igh@/Bcl2 (T(14;18)) (Eg Follicular Lymphoma)	MP Criteria: Procedures/services reviewed against Medical			
01270	Translocation Analysis Major Breakpoint Region (Mbr) And	-			
81278	Minor Cluster Region (Mcr) Breakpoints Qualitative Or	Policy Criteria. Submit for Recommended Clinical Review to	-	_	-
	Quantitative	avoid post-service review by Carelon.			
	Jak2 (Janus Kinase 2) (Eg Myeloproliferative Disorder)	MP Criteria: Procedures/services reviewed against Medical			
81279	Targeted Sequence Analysis (Eg Exons 12 And 13)	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by Carelon.			
	Ifnl3 (Interferon Lambda 3) (Eg Drug Response) Gene	MP Criteria: Procedures/services reviewed against Medical			
81283	Analysis Rs12979860 Variant	Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review by Carelon.			_
	Fxn (Frataxin) (Eg Friedreich Ataxia) Gene Analysis;	MP Criteria: Procedures/services reviewed against Medical			
81284	Evaluation To Detect Abnormal (Expanded) Alleles	Policy Criteria. Submit for Recommended Clinical Review to			
	, , , , , , , , , , , , , , , , , , ,	avoid post-service review by Carelon.	_	_	_
	Fxn (Frataxin) (Eg Friedreich Ataxia) Gene Analysis;	MP Criteria: Procedures/services reviewed against Medical			
81285	Characterization Of Alleles (Eg Expanded Size)	Policy Criteria. Submit for Recommended Clinical Review to			
	ondrate in any menes (18 Expanded 5125)	avoid post-service review by Carelon.	_	_	_
	Fxn (Frataxin) (Eg Friedreich Ataxia) Gene Analysis; Full	MP Criteria: Procedures/services reviewed against Medical			
81286	Gene Sequence	Policy Criteria. Submit for Recommended Clinical Review to			
	Gene Sequence	avoid post-service review by Carelon.	-	-	-
	Mgmt (O-6-Methylguanine-Dna Methyltransferase) (Eg	MP Criteria: Procedures/services reviewed against Medical			
81287	Glioblastoma Multiforme) Promoter Methylation Analysis	Policy Criteria. Submit for Recommended Clinical Review to			
51207	Gilobiastoria Multifornie) Profficier Metriylation Affalysis	avoid post-service review by Carelon.	-	-	-
		avoiu post-service review by Careion.			

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	Mlh1 (Mutl Homolog 1 Colon Cancer Nonpolyposis Type 2)	MP Criteria: Procedures/services reviewed against Medical			
81288	(Eg Hereditary Non-Polyposis Colorectal Cancer Lynch	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Syndrome) Gene Analysis; Promoter Methylation Analysis	avoid post-service review by Carelon.			
	Fxn (Frataxin) (Eg Friedreich Ataxia) Gene Analysis; Known	MP Criteria: Procedures/services reviewed against Medical			
81289	Familial Variant(S)	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by Carelon.			
	Mcoln1 (Mucolipin 1) (Eg Mucolipidosis Type Iv) Gene	MP Criteria: Procedures/services reviewed against Medical			
81290	Analysis Common Variants (Eg Ivs3-2A>G Del6.4Kb)	Policy Criteria. Submit for Recommended Clinical Review to	_		_
		avoid post-service review by Carelon.			
	Mthfr (5 10-Methylenetetrahydrofolate Reductase) (Eg	MP Criteria: Procedures/services reviewed against Medical			
81291	Hereditary Hypercoagulability) Gene Analysis Common	Policy Criteria. Submit for Recommended Clinical Review to			
	Variants (Eg 677T 1298C)	avoid post-service review by Carelon.	_	_	_
	Mlh1 (Mutl Homolog 1 Colon Cancer Nonpolyposis Type 2)	MP Criteria: Procedures/services reviewed against Medical			
81292	(Eg Hereditary Non-Polyposis Colorectal Cancer Lynch	Policy Criteria. Submit for Recommended Clinical Review to			
81292		•	_	_	_
	Syndrome) Gene Analysis; Full Sequence Analysis	avoid post-service review by Carelon. MP Criteria: Procedures/services reviewed against Medical			+
04.202	, , ,	·			
81293	(Eg Hereditary Non-Polyposis Colorectal Cancer Lynch	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Syndrome) Gene Analysis; Known Familial Variants	avoid post-service review by Carelon.			
	Mlh1 (Mutl Homolog 1 Colon Cancer Nonpolyposis Type 2)	MP Criteria: Procedures/services reviewed against Medical			
81294	(Eg Hereditary Non-Polyposis Colorectal Cancer Lynch	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Syndrome) Gene Analysis; Duplication/Deletion Variants	avoid post-service review by Carelon.			
	Msh2 (Muts Homolog 2 Colon Cancer Nonpolyposis Type 1)	MP Criteria: Procedures/services reviewed against Medical			
81295	(Eg Hereditary Non-Polyposis Colorectal Cancer Lynch	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Syndrome) Gene Analysis; Full Sequence Analysis	avoid post-service review by Carelon.			
	Msh2 (Muts Homolog 2 Colon Cancer Nonpolyposis Type 1)	MP Criteria: Procedures/services reviewed against Medical			
81296	(Eg Hereditary Non-Polyposis Colorectal Cancer Lynch	Policy Criteria. Submit for Recommended Clinical Review to			
	Syndrome) Gene Analysis; Known Familial Variants	avoid post-service review by Carelon.	_		_
	Msh2 (Muts Homolog 2 Colon Cancer Nonpolyposis Type 1)				
81297	(Eg Hereditary Non-Polyposis Colorectal Cancer Lynch	Policy Criteria. Submit for Recommended Clinical Review to			
01237	Syndrome) Gene Analysis; Duplication/Deletion Variants	avoid post-service review by Carelon.	_	_	_
	Msh6 (Muts Homolog 6 [E. Coli]) (Eg. Hereditary Non-	MP Criteria: Procedures/services reviewed against Medical			
81298	, , , , , , , , , , , , , , , , , , , ,	Policy Criteria. Submit for Recommended Clinical Review to			
81298	Polyposis Colorectal Cancer Lynch Syndrome) Gene	·	_	-	-
	Analysis; Full Sequence Analysis	avoid post-service review by Carelon.			
	Msh6 (Muts Homolog 6 [E. Coli]) (Eg Hereditary Non-	MP Criteria: Procedures/services reviewed against Medical			
81299	Polyposis Colorectal Cancer Lynch Syndrome) Gene	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Analysis; Known Familial Variants	avoid post-service review by Carelon.			
	Msh6 (Muts Homolog 6 [E. Coli]) (Eg Hereditary Non-	MP Criteria: Procedures/services reviewed against Medical			
81300	Polyposis Colorectal Cancer Lynch Syndrome) Gene	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Analysis; Duplication/Deletion Variants	avoid post-service review by Carelon.			
	Microsatellite Instability Analysis (Eg Hereditary Non-				
	Polyposis Colorectal Cancer Lynch Syndrome) Of Markers	MP Criteria: Procedures/services reviewed against Medical			
81301	For Mismatch Repair Deficiency (Eg Bat25 Bat26) Includes	Policy Criteria. Submit for Recommended Clinical Review to			
	Comparison Of Neoplastic And Normal Tissue If Performed	avoid post-service review by Carelon.	_	_	_
	comparison of Neophastic And Normal rissue in Performed	area post service review by curcion.			
	Mecp2 (Methyl Cpg Binding Protein 2) (Eg Rett Syndrome)	MP Criteria: Procedures/services reviewed against Medical			+
81302	Gene Analysis; Full Sequence Analysis	Policy Criteria. Submit for Recommended Clinical Review to			
01302	Gene Analysis, Full Sequence Analysis	•	_	-	-
		avoid post-service review by Carelon.			1

	Mecp2 (Methyl Cpg Binding Protein 2) (Eg Rett Syndrome)	MP Criteria: Procedures/services reviewed against Medical			
81303	Gene Analysis; Known Familial Variant	Policy Criteria. Submit for Recommended Clinical Review to			
	• •	avoid post-service review by Carelon.	_	_	_
	Mecp2 (Methyl Cpg Binding Protein 2) (Eg Rett Syndrome)	MP Criteria: Procedures/services reviewed against Medical			
81304	Gene Analysis; Duplication/Deletion Variants	Policy Criteria. Submit for Recommended Clinical Review to	_		_
	, , , ,	avoid post-service review by Carelon.			
	Myd88 (Myeloid Differentiation Primary Response 88) (Eg	MP Criteria: Procedures/services reviewed against Medical			
81305	Waldenstrom'S Macroglobulinemia Lymphoplasmacytic	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Leukemia) Gene Analysis P.Leu265Pro (L265P) Variant	avoid post-service review by Carelon.			
	Nudt15 (Nudix Hydrolase 15) (Eg Drug Metabolism) Gene	MP Criteria: Procedures/services reviewed against Medical			
81306	Analysis Common Variant(S) (Eg *2 *3 *4 *5 *6)	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by Carelon.			
	Palb2 (Partner And Localizer Of Brca2) (Eg Breast And	MP Criteria: Procedures/services reviewed against Medical			
81307	Pancreatic Cancer) Gene Analysis; Full Gene Sequence	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by Carelon.			
	Palb2 (Partner And Localizer Of Brca2) (Eg Breast And	MP Criteria: Procedures/services reviewed against Medical			
81308	Pancreatic Cancer) Gene Analysis; Known Familial Variant	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by Carelon.			
	Pik3Ca (Phosphatidylinositol-4 5-Biphosphate 3-Kinase	MP Criteria: Procedures/services reviewed against Medical			
81309	Catalytic Subunit Alpha) (Eg Colorectal And Breast Cancer)	Policy Criteria. Submit for Recommended Clinical Review to			
01303	Gene Analysis Targeted Sequence Analysis (Eg Exons 7 9	avoid post-service review by Carelon.	_	-	_
	20)	·			
	Npm1 (Nucleophosmin) (Eg Acute Myeloid Leukemia) Gene	MP Criteria: Procedures/services reviewed against Medical			
81310	Analysis Exon 12 Variants	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by Carelon.			
	Nras (Neuroblastoma Ras Viral [V-Ras] Oncogene Homolog)	MP Criteria: Procedures/services reviewed against Medical			
81311	(Eg Colorectal Carcinoma) Gene Analysis Variants In Exon 2	Policy Criteria. Submit for Recommended Clinical Review to			
01311	(Eg Codons 12 And 13) And Exon 3 (Eg Codon 61)	avoid post-service review by Carelon.	_	_	_
		· ·			
	Pabpn1 (Poly[A] Binding Protein Nuclear 1) (Eg	MP Criteria: Procedures/services reviewed against Medical			
81312	Oculopharyngeal Muscular Dystrophy) Gene Analysis	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Evaluation To Detect Abnormal (Eg Expanded) Alleles	avoid post-service review by Carelon.			
	Pca3/Klk3 (Prostate Cancer Antigen 3 [Non-Protein	MP Criteria: Procedures/services reviewed against Medical			
81313	Coding]/Kallikrein-Related Peptidase 3 [Prostate Specific	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Antigen]) Ratio (Eg Prostate Cancer)	avoid post-service review by Carelon.			
	Pdgfra (Platelet-Derived Growth Factor Receptor Alpha	MP Criteria: Procedures/services reviewed against Medical			
81314	Polypeptide) (Eg Gastrointestinal Stromal Tumor [Gist])	Policy Criteria. Submit for Recommended Clinical Review to			L
	Gene Analysis Targeted Sequence Analysis (Eg Exons 12	avoid post-service review by Carelon.	_	_	_
	18)				
	Pml/Raralpha (T(15;17)) (Promyelocytic Leukemia/Retinoic	MD Colored December 1			
	Acid Receptor Alpha) (Eg Promyelocytic Leukemia)	MP Criteria: Procedures/services reviewed against Medical			
81315	Translocation Analysis; Common Breakpoints (Eg Intron 3	Policy Criteria. Submit for Recommended Clinical Review to	_	-	_
	And Intron 6) Qualitative Or Quantitative	avoid post-service review by Carelon.			

81316	Pml/Raralpha (T(15;17)) (Promyelocytic Leukemia/Retinoic Acid Receptor Alpha) (Eg Promyelocytic Leukemia) Translocation Analysis; Single Breakpoint (Eg Intron 3 Intron 6 Or Exon 6) Qualitative Or Quantitative	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
81317	Pms2 (Postmeiotic Segregation Increased 2 [S. Cerevisiae]) (Eg Hereditary Non-Polyposis Colorectal Cancer Lynch Syndrome) Gene Analysis; Full Sequence Analysis	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
81318	Pms2 (Postmeiotic Segregation Increased 2 [S. Cerevisiae]) (Eg Hereditary Non-Polyposis Colorectal Cancer Lynch Syndrome) Gene Analysis; Known Familial Variants	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
81319	Pms2 (Postmeiotic Segregation Increased 2 [S. Cerevisiae]) (Eg Hereditary Non-Polyposis Colorectal Cancer Lynch Syndrome) Gene Analysis; Duplication/Deletion Variants	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
81320	Plcg2 (Phospholipase C Gamma 2) (Eg Chronic Lymphocytic Leukemia) Gene Analysis Common Variants (Eg R665W S707F L845F)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	-	-
81321	Pten (Phosphatase And Tensin Homolog) (Eg Cowden Syndrome Pten Hamartoma Tumor Syndrome) Gene Analysis; Full Sequence Analysis	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
81322	Pten (Phosphatase And Tensin Homolog) (Eg Cowden Syndrome Pten Hamartoma Tumor Syndrome) Gene Analysis; Known Familial Variant	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
81323	Pten (Phosphatase And Tensin Homolog) (Eg Cowden Syndrome Pten Hamartoma Tumor Syndrome) Gene Analysis; Duplication/Deletion Variant	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
81324	Pmp22 (Peripheral Myelin Protein 22) (Eg Charcot-Marie- Tooth Hereditary Neuropathy With Liability To Pressure Palsies) Gene Analysis; Duplication/Deletion Analysis	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	-	-
81325	Pmp22 (Peripheral Myelin Protein 22) (Eg Charcot-Marie- Tooth Hereditary Neuropathy With Liability To Pressure Palsies) Gene Analysis; Full Sequence Analysis	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	-	-
81326	Pmp22 (Peripheral Myelin Protein 22) (Eg Charcot-Marie- Tooth Hereditary Neuropathy With Liability To Pressure Palsies) Gene Analysis; Known Familial Variant	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	-	-
81327	Sept9 (Septin9) (Eg Colorectal Cancer) Promoter Methylation Analysis	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_	-
81328	Slco1B1 (Solute Carrier Organic Anion Transporter Family Member 1B1) (Eg Adverse Drug Reaction) Gene Analysis Common Variant(S) (Eg *5)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
81330	Smpd1 (Sphingomyelin Phosphodiesterase 1 Acid Lysosomal) (Eg Niemann-Pick Disease Type A) Gene Analysis Common Variants (Eg R496L L302P Fsp330)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	-	_

81331	Snrpn/Ube3A (Small Nuclear Ribonucleoprotein Polypeptide N And Ubiquitin Protein Ligase E3A) (Eg Prader-Willi Syndrome And/Or Angelman Syndrome) Methylation Analysis	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	_
81332	Serpina1 (Serpin Peptidase Inhibitor Clade A Alpha-1 Antiproteinase Antitrypsin Member 1) (Eg Alpha-1- Antitrypsin Deficiency) Gene Analysis Common Variants (Eg *S And *Z)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
81333	Tgfbi (Transforming Growth Factor Beta-Induced) (Eg Corneal Dystrophy) Gene Analysis Common Variants (Eg R124H R124C R124L R555W R555Q)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	-	_
81334	Runx1 (Runt Related Transcription Factor 1) (Eg Acute Myeloid Leukemia Familial Platelet Disorder With Associated Myeloid Malignancy) Gene Analysis Targeted Sequence Analysis (Eg Exons 3-8)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
81335	Tpmt (Thiopurine S-Methyltransferase) (Eg Drug Metabolism) Gene Analysis Common Variants (Eg *2 *3)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	-	-
81336	Smn1 (Survival Of Motor Neuron 1 Telomeric) (Eg Spinal Muscular Atrophy) Gene Analysis; Full Gene Sequence	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
81337	Smn1 (Survival Of Motor Neuron 1 Telomeric) (Eg Spinal Muscular Atrophy) Gene Analysis; Known Familial Sequence Variant(S)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	-	-
81338	Mpl (Mpl Proto-Oncogene Thrombopoietin Receptor) (Eg Myeloproliferative Disorder) Gene Analysis; Common Variants (Eg W515A W515K W515L W515R)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
81339	Mpl (Mpl Proto-Oncogene Thrombopoietin Receptor) (Eg Myeloproliferative Disorder) Gene Analysis; Sequence Analysis Exon 10	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
81340	Trb@ (T Cell Antigen Receptor Beta) (Eg Leukemia And Lymphoma) Gene Rearrangement Analysis To Detect Abnormal Clonal Population(S); Using Amplification Methodology (Eg Polymerase Chain Reaction)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
81341	Trb@ (T Cell Antigen Receptor Beta) (Eg Leukemia And Lymphoma) Gene Rearrangement Analysis To Detect Abnormal Clonal Population(S); Using Direct Probe Methodology (Eg Southern Blot)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
81342	Trg@ (T Cell Antigen Receptor Gamma) (Eg Leukemia And Lymphoma) Gene Rearrangement Analysis Evaluation To Detect Abnormal Clonal Population(S)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
81343	Ppp2R2B (Protein Phosphatase 2 Regulatory Subunit Bbeta) (Eg Spinocerebellar Ataxia) Gene Analysis Evaluation To Detect Abnormal (Eg Expanded) Alleles	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
81344	Tbp (Tata Box Binding Protein) (Eg Spinocerebellar Ataxia) Gene Analysis Evaluation To Detect Abnormal (Eg Expanded) Alleles	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-

	Tort (Tolemerose Boyerse Transcriptore) (Fg. Thyroid	MP Criteria: Procedures/services reviewed against Medical			
01245	Tert (Telomerase Reverse Transcriptase) (Eg Thyroid	·			
81345	Carcinoma Glioblastoma Multiforme) Gene Analysis	Policy Criteria. Submit for Recommended Clinical Review to	_	-	_
	Targeted Sequence Analysis (Eg Promoter Region)	avoid post-service review by Carelon.			
	Tyms (Thymidylate Synthetase) (Eg 5-Fluorouracil/5-Fu	MP Criteria: Procedures/services reviewed against Medical			
81346	Drug Metabolism) Gene Analysis Common Variant(S) (Eg	Policy Criteria. Submit for Recommended Clinical Review to	_	-	_
	Tandem Repeat Variant)	avoid post-service review by Carelon.			
	Sf3B1 (Splicing Factor [3B] Subunit B1) (Eg Myelodysplastic	MP Criteria: Procedures/services reviewed against Medical			
81347	Syndrome/Acute Myeloid Leukemia) Gene Analysis	Policy Criteria. Submit for Recommended Clinical Review to			
013 17	Common Variants (Eg A672T E622D L833F R625C R625L)	avoid post-service review by Carelon.	_	_	_
		avoid post-service review by careion.			
	Srsf2 (Serine And Arginine-Rich Splicing Factor 2) (Eg	MP Criteria: Procedures/services reviewed against Medical			
81348	Myelodysplastic Syndrome Acute Myeloid Leukemia) Gene	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Analysis Common Variants (Eg P95H P95L)	avoid post-service review by Carelon.			
	Cytogenomic (Genome-Wide) Analysis For Constitutional	MP Criteria: Procedures/services reviewed against Medical			
01240	Chromosomal Abnormalities; Interrogation Of Genomic	·			
81349	Regions For Copy Number And Loss-Of-Heterozygosity	Policy Criteria. Submit for Recommended Clinical Review to	_	-	_
	Variants Low-Pass Sequencing Analysis	avoid post-service review by Carelon.			
	Ugt1A1 (Udp Glucuronosyltransferase 1 Family Polypeptide	NAD Criteria: Dragaduras/sociates assistant description			
04350	A1) (Eg Drug Metabolism Hereditary Unconjugated	MP Criteria: Procedures/services reviewed against Medical			
81350	Hyperbilirubinemia [Gilbert Syndrome]) Gene Analysis	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Common Variants (Eg *28 *36 *37)	avoid post-service review by Carelon.			
	Tp53 (Tumor Protein 53) (Eg. Li-Fraumeni Syndrome) Gene	MP Criteria: Procedures/services reviewed against Medical			
81351	Analysis; Full Gene Sequence	Policy Criteria. Submit for Recommended Clinical Review to			
	,,	avoid post-service review by Carelon.	_	_	_
	Tp53 (Tumor Protein 53) (Eg Li-Fraumeni Syndrome) Gene	MP Criteria: Procedures/services reviewed against Medical			
81352	Analysis; Targeted Sequence Analysis (Eg. 4 Oncology)	Policy Criteria. Submit for Recommended Clinical Review to			
	7 mis. 1900, 1 million ocquerios 7 mis. 1900 (28 1 0 missis 87)	avoid post-service review by Carelon.	_	_	-
	Tp53 (Tumor Protein 53) (Eg Li-Fraumeni Syndrome) Gene	MP Criteria: Procedures/services reviewed against Medical			
81353	Analysis; Known Familial Variant	Policy Criteria. Submit for Recommended Clinical Review to			
01333	Analysis, known rummur variant	avoid post-service review by Carelon.	_	_	_
	Vkorc1 (Vitamin K Epoxide Reductase Complex Subunit 1)	MP Criteria: Procedures/services reviewed against Medical			
81355	(Eg Warfarin Metabolism) Gene Analysis Common	Policy Criteria. Submit for Recommended Clinical Review to			
01333	Variant(S) (Eg -1639G>A C.173+1000C>T)	avoid post-service review by Carelon.	_	-	_
	U2Af1 (U2 Small Nuclear Rna Auxiliary Factor 1) (Eg	avoid post-service review by careion.			
	Myelodysplastic Syndrome Acute Myeloid Leukemia) Gene	MP Criteria: Procedures/services reviewed against Medical			
81357		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Analysis Common Variants (Eg S34F S34Y Q157R Q157P)	avoid post-service review by Carelon.			
	Zrsr2 (Zinc Finger Ccch-Type Rna Binding Motif And				+
	, , , , , , , , , , , , , , , , , , , ,	MP Criteria: Procedures/services reviewed against Medical			
81360	Serine/Arginine-Rich 2) (Eg Myelodysplastic Syndrome	Policy Criteria. Submit for Recommended Clinical Review to	_		_
	Acute Myeloid Leukemia) Gene Analysis Common Variant(S)	avoid post-service review by Carelon.			
	(Eg E65Fs E122Fs R448Fs)	· ·			+
	Hbb (Hemoglobin Subunit Beta) (Eg Sickle Cell Anemia	MP Criteria: Procedures/services reviewed against Medical			
81361	Beta Thalassemia Hemoglobinopathy); Common Variant(S)	Policy Criteria. Submit for Recommended Clinical Review to	_	-	_
	(Eg Hbs Hbc Hbe)	avoid post-service review by Carelon.			
	Hbb (Hemoglobin Subunit Beta) (Eg Sickle Cell Anemia	MP Criteria: Procedures/services reviewed against Medical			
81362	Beta Thalassemia Hemoglobinopathy); Known Familial	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Variant(S)	avoid post-service review by Carelon.			

	Hbb (Hemoglobin Subunit Beta) (Eg Sickle Cell Anemia	MP Criteria: Procedures/services reviewed against Medical		1	
81363	Beta Thalassemia Hemoglobinopathy); Duplication/Deletion	,			
01303		avoid post-service review by Carelon.	_	-	_
		MP Criteria: Procedures/services reviewed against Medical			
81364	,	Policy Criteria. Submit for Recommended Clinical Review to			
81304	9 , ,,,	avoid post-service review by Carelon.	-	-	_
	Molecular Pathology Procedure Level 1 (Eg Identification Of	avoid post-service review by Carelon.			
	Single Germline Variant [Eg Snp] By Techniques Such As				
	Restriction Enzyme Digestion Or Melt Curve Analysis) Acadm				
	(Acyl-Coa Dehydrogenase C-4 To C-12 Straight Chain Mcad)				
	(Eg Medium Chain Acyl Dehydrogenase Deficiency) K304E				
	Variant Ace (Angiotensin Converting Enzyme) (Eg Hereditary				
	Blood Pressure Regulation) Insertion/Deletion Variant Agtr1				
	(Angiotensin li Receptor Type 1) (Eg Essential				
	Hypertension) 1166A>C Variant Bckdha (Branched Chain				
	Keto Acid Dehydrogenase E1 Alpha Polypeptide) (Eg Maple				
	Syrup Urine Disease Type 1A) Y438N Variant Ccr5				
	(Chemokine C-C Motif Receptor 5) (Eg Hiv Resistance) 32-				
	Bp Deletion Mutation/794 825Del32 Deletion Clrn1 (Clarin				
	1) (Eg Usher Syndrome Type 3) N48K Variant F2				
	(Coagulation Factor 2) (Eg Hereditary Hypercoagulability)				
	1199G>A Variant F5 (Coagulation Factor V) (Eg Hereditary				
	Hypercoagulability) Hr2 Variant F7 (Coagulation Factor Vii				
04.400		MP Criteria: Procedures/services reviewed against Medical			
81400		Policy Criteria. Submit for Recommended Clinical Review to	-	-	_
	, , , , , , , , , , , , , , , , , , , ,	avoid post-service review by Carelon.			
	Hypercoagulability) V34L Variant Fgb (Fibrinogen Beta				
	Chain) (Eg Hereditary Ischemic Heart Disease) -455G>A				
	Variant Fgfr1 (Fibroblast Growth Factor Receptor 1) (Eg				
	Pfeiffer Syndrome Type 1 Craniosynostosis) P252R Variant				
	Fgfr3 (Fibroblast Growth Factor Receptor 3) (Eg Muenke				
	Syndrome) P250R Variant Fktn (Fukutin) (Eg Fukuyama				
	Congenital Muscular Dystrophy) Retrotransposon Insertion				
	Variant Gne (Glucosamine [Udp-N-Acetyl]-2-Epimerase/N-				
	Acetylmannosamine Kinase) (Eg Inclusion Body Myopathy 2				
	[Ibm2] Nonaka Myopathy) M712T Variant Ivd (Isovaleryl-				
	Coa Dehydrogenase) (Eg. Isovaleric Acidemia) A282V				
	Variant Lct (Lactase-Phlorizin Hydrolase) (Eg Lactose				
	Intolerance) 13910 C>T Variant Neb (Nebulin) (Eg Nemaline				
	Myopathy 2) Exon 55 Deletion Variant Pcdh15				
	(Protocadherin-Related 15) (Eg Usher Syndrome Type 1F)				
	R245X Variant Serpine1 (Serpine Peptidase Inhi				

Molecular Pathology Procedure Level 2 (Eg 2-10 Snps 1 Methylated Variant Or 1 Somatic Variant [Typically Using Nonsequencing Target Variant Analysis] Or Detection Of A Dynamic Mutation Disorder/Triplet Repeat) Abcc8 (Atp-Binding Cassette Sub-Family C [Cftr/Mrp] Member 8) (Eg Familial Hyperinsulinism) Common Variants (Eg C.3898-9G>A [C.3992-9G>A] F1388Del) Abl1 (Abl Proto-Oncogene 1 Non-Receptor Tyrosine Kinase) (Eg Acquired Imatinib Resistance) T315I Variant Acadm (Acyl-Coa Dehydrogenase C-4 To C-12 Straight Chain Mcad) (Eg Medium Chain Acyl Dehydrogenase Deficiency) Commons Variants (Eg K304E Y42H) Adrb2 (Adrenergic Beta-2 Receptor Surface) (Eg Drug Metabolism) Common Variants (Eg G16R Q27E) Apob (Apolipoprotein B) (Eg Familial Hypercholesterolemia Type B) Common Variants (Eg R3500Q R3500W) Apoe (Apolipoprotein E) (Eg Hyperlipoproteinemia Type Iii Cardiovascular Disease Alzheimer Disease) Common Variants (Eg *2 *3 *4) Cbfb/Myh11 (Inv(16)) (Eg Acute MP Criteria: Procedures/services reviewed against Medical 81401 Policy Criteria. Submit for Recommended Clinical Review to Myeloid Leukemia) Qualitative And Quantitative If Performed Cbs (Cystathionine-Beta-Synthase) (Eg avoid post-service review by Carelon. Homocystinuria Cystathionine Beta-Synthase Deficiency) Common Variants (Eg 1278T G307S) Cfh/Arms2 (Complement Factor H/Age-Related Maculopathy Susceptibility 2) (Eg. Macular Degeneration) Common Variants (Eg Y402H [Cfh] A69S [Arms2]) Dek/Nup214 (T(6;9)) (Eg Acute Myeloid Leukemia) Translocation Analysis Qualitative And Quantitative If Performed E2A/Pbx1 (T(1;19)) (Eg Acute Lymphocytic Leukemia) Translocation Analysis Qualitative And Quantitative If Performed EmI4/Alk (Inv(2)) (Eg Non-Small Cell Lung Cancer) Translocation Or Inversion Analysis Etv6/Runx1 (T(12;21)) (Eg Acute Lymphocytic Leukemia) Translocation Analysis Qualitative And Quantitative If Performed Ewsr1/Atf1 (T(12;22)) (Eg Clear Cell Sarcoma) Translocation Analysis Qualitative And Quantitative If Performed Ewsr1/Erg (T(21;22)) (Eg Ewing Sarcoma/Peripheral Neuroectodermal Tumor) Translocation A

81402	Molecular Pathology Procedure Level 3 (Eg >10 Snps 2-10 Methylated Variants Or 2-10 Somatic Variants [Typically Using Non-Sequencing Target Variant Analysis] Immunoglobulin And T-Cell Receptor Gene Rearrangements Duplication/Deletion Variants Of 1 Exon Loss Of Heterozygosity [Loh] Uniparental Disomy [Upd]) Chromosome 1P-/19Q- (Eg Glial Tumors) Deletion Analysis Chromosome 18Q- (Eg D18S55 D18S58 D18S61 D18S64 And D18S69) (Eg Colon Cancer) Allelic Imbalance Assessment (le Loss Of Heterozygosity) Col1A1/Pdgfb (T(17;22)) (Eg Dermatofibrosarcoma Protuberans) Translocation Analysis Multiple Breakpoints Qualitative And Quantitative If Performed Cyp21A2 (Cytochrome P450 Family 21 Subfamily A Polypeptide 2) (Eg Congenital Adrenal Hyperplasia 21-Hydroxylase Deficiency) Common Variants (Eg Ivs2-13G P30L I172N Exon 6 Mutation Cluster [I235N V236E M238K] V281L L307Ffsx6 Q318X R356W P453S G110Vfsx21 30-Kb Deletion Variant) Esr1/Pgr (Receptor 1/Progesterone Receptor) Ratio (Eg Breast Cancer) Mefv (Mediterranean Fever) (Eg Familial Mediterranean Fever) Common Variants (Eg E148Q P369S F479L M680I I692Del M694V M694I K695R V726A A744S R761H) Trd@ (T Cell Antigen Receptor Delta) (Eg Leukemia And Lymphoma) Gene Rearrangement Analysis Evaluation To Detect Abnormal Clonal Population Uniparental Disomy (Upd) (Eg Russell-Silver Syndrome Prader-Willi/Angelman Syndrome) Short Tandem Repeat (Str) Analysis	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_	_	
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Molecular Pathology Procedure Level 4 (Eg Analysis Of Single Exon By Dna Sequence Analysis Analysis Of >10 Amplicons Using Multiplex Pcr In 2 Or More Independent Reactions Mutation Scanning Or Duplication/Deletion Variants Of 2-5 Exons) Ang (Angiogenin Ribonuclease Rnase A Family 5) (Eg Amyotrophic Lateral Sclerosis) Full Gene Sequence Arx (Aristaless Related Homeobox) (Eg X-Linked Lissencephaly With Ambiguous Genitalia X-Linked Intellectual Disability) Duplication/Deletion Analysis Cel (Carboxyl Ester Lipase [Bile Salt-Stimulated Lipase]) (Eg Maturity-Onset Diabetes Of The Young [Mody]) Targeted Sequence Analysis Of Exon 11 (Eg C.1785Delc C.1686Delt) Ctnnb1 (Catenin [Cadherin-Associated Protein] Beta 1 88Kda) (Eg Desmoid Tumors) Targeted Sequence Analysis (Eg Exon 3) Daz/Sry (Deleted In Azoospermia And Sex Determining Region Y) (Eg Male Infertility) Common Deletions (Eg Azfa Azfb Azfc Azfd) Dnmt3A (Dna [Cytosine-5-]-Methyltransferase 3 Alpha) (Eg Acute Myeloid MP Criteria: Procedures/services reviewed against Medical 81403 Leukemia) Targeted Sequence Analysis (Eg Exon 23) Epcam Policy Criteria. Submit for Recommended Clinical Review to (Epithelial Cell Adhesion Molecule) (Eg Lynch Syndrome) avoid post-service review by Carelon. Duplication/Deletion Analysis F8 (Coagulation Factor Viii) (Eg Hemophilia A) Inversion Analysis Intron 1 And Intron 22A F12 (Coagulation Factor Xii [Hageman Factor]) (Eg Angioedema Hereditary Type Iii; Factor Xii Deficiency) Targeted Sequence Analysis Of Exon 9 Fgfr3 (Fibroblast Growth Factor Receptor 3) (Eg Isolated Craniosynostosis) Targeted Sequence Analysis (Eg Exon 7) (For Targeted Sequence Analysis Of Multiple Fgfr3 Exons Use 81404) Gjb1 (Gap Junction Protein Beta 1) (Eg Charcot-Marie-Tooth X-Linked) Full Gene Sequence Gnag (Guanine Nucleotide-Binding Protein G[Q] Subunit Alpha) (Eg Uveal Melanoma) Common Variants (Eg R183 Q209) Human Erythrocyte Antigen Gene Analyses (Eg Slc14A1 [Kidd Blood Group] Bcam [Lutheran Blood Group] Icam4 [Landsteiner-Wiener Blood Group] Slc4A1 [Diego Blood Group] Aqp1 [Colton Blood Group] Ermap [Scianna Blood G

Molecular Pathology Procedure Level 5 (Eg Analysis Of 2-5 Exons By Dna Sequence Analysis Mutation Scanning Or Duplication/Deletion Variants Of 6-10 Exons Or Characterization Of A Dynamic Mutation Disorder/Triplet Repeat By Southern Blot Analysis) Acads (Acyl-Coa Dehydrogenase C-2 To C-3 Short Chain) (Eg Short Chain Acyl-Coa Dehydrogenase Deficiency) Targeted Sequence Analysis (Eg Exons 5 And 6) Aqp2 (Aquaporin 2 [Collecting Duct]) (Eg Nephrogenic Diabetes Insipidus) Full Gene Sequence Arx (Aristaless Related Homeobox) (Eg. X-Linked Lissencephaly With Ambiguous Genitalia X-Linked Intellectual Disability) Full Gene Sequence Avpr2 (Arginine Vasopressin Receptor 2) (Eg Nephrogenic Diabetes Insipidus) Full Gene Sequence Bbs10 (Bardet-Biedl Syndrome 10) (Eg Bardet-Biedl Syndrome) Full Gene Sequence Btd (Biotinidase) (Eg Biotinidase Deficiency) Full Gene Sequence C10Orf2 (Chromosome 10 Open Reading Frame 2) (Eg Mitochondrial Dna Depletion Syndrome) Full MP Criteria: Procedures/services reviewed against Medical 81404 Policy Criteria. Submit for Recommended Clinical Review to Gene Sequence Cav3 (Caveolin 3) (Eg Cav3-Related Distal Myopathy Limb-Girdle Muscular Dystrophy Type 1C) Full avoid post-service review by Carelon. Gene Sequence Cd40Lg (Cd40 Ligand) (Eg X-Linked Hyper Igm Syndrome) Full Gene Sequence Cdkn2A (Cyclin-Dependent Kinase Inhibitor 2A) (Eg Cdkn2A-Related Cutaneous Malignant Melanoma Familial Atypical Mole-Malignant Melanoma Syndrome) Full Gene Sequence Clrn1 (Clarin 1) (Eg Usher Syndrome Type 3) Full Gene Sequence Cox6B1 (Cytochrome C Oxidase Subunit Vib Polypeptide 1) (Eg Mitochondrial Respiratory Chain Complex Iv Deficiency) Full Gene Sequence Cpt2 (Carnitine Palmitoyltransferase 2) (Eg Carnitine Palmitoyltransferase Ii Deficiency) Full Gene Sequence Crx (Cone-Rod Homeobox) (Eg Cone-Rod Dystrophy 2 Leber Congenital Amaurosis) Full Gene Sequence Cyp1B1 (Cytochrome P450 Family 1 Subfamily B Polypeptide 1) (Eg Primary Congenital Glaucoma) Full Gene Sequence Egr2 (Early Growth Response 2) (Eg Charcot-Marie-Tooth) Full Gene Sequence Emd (Emerin) (Eg Emery-Dreifuss Muscular D

Molecular Pathology Procedure Level 6 (Eg Analysis Of 6-10 Exons By Dna Sequence Analysis Mutation Scanning Or Duplication/Deletion Variants Of 11-25 Exons Regionally Targeted Cytogenomic Array Analysis) Abcd1 (Atp-Binding Cassette Sub-Family D [Ald] Member 1) (Eg Adrenoleukodystrophy) Full Gene Sequence Acads (Acyl-Coa Dehydrogenase C-2 To C-3 Short Chain) (Eg Short Chain Acyl-Coa Dehydrogenase Deficiency) Full Gene Sequence Acta2 (Actin Alpha 2 Smooth Muscle Aorta) (Eg Thoracic Aortic Aneurysms And Aortic Dissections) Full Gene Sequence Actc1 (Actin Alpha Cardiac Muscle 1) (Eg Familial Hypertrophic Cardiomyopathy) Full Gene Sequence Ankrd1 (Ankyrin Repeat Domain 1) (Eg Dilated Cardiomyopathy) Full Gene Sequence Aptx (Aprataxin) (Eg Ataxia With Oculomotor Apraxia 1) Full Gene Sequence Arsa (Arylsulfatase A) (Eg Arylsulfatase A Deficiency) Full Gene Sequence Bckdha (Branched Chain Keto Acid Dehydrogenase E1 Alpha Polypeptide) (Eg Maple Syrup Urine Disease Type MP Criteria: Procedures/services reviewed against Medical 81405 1A) Full Gene Sequence Bcs1L (Bcs1-Like [S. Cerevisiae]) (Eg Policy Criteria. Submit for Recommended Clinical Review to Leigh Syndrome Mitochondrial Complex Iii Deficiency avoid post-service review by Carelon. Gracile Syndrome) Full Gene Sequence Bmpr2 (Bone Morphogenetic Protein Receptor Type Ii [Serine/Threonine Kinase]) (Eg Heritable Pulmonary Arterial Hypertension) Duplication/Deletion Analysis Casq2 (Calsequestrin 2 [Cardiac Muscle]) (Eg Catecholaminergic Polymorphic Ventricular Tachycardia) Full Gene Sequence Casr (Calcium-Sensing Receptor) (Eg. Hypocalcemia) Full Gene Sequence Cdkl5 (Cyclin-Dependent Kinase-Like 5) (Eg Early Infantile Epileptic Encephalopathy) Duplication/Deletion Analysis Chrna4 (Cholinergic Receptor Nicotinic Alpha 4) (Eg Nocturnal Frontal Lobe Epilepsy) Full Gene Sequence Chrnb2 (Cholinergic Receptor Nicotinic Beta 2 [Neuronal]) (Eg Nocturnal Frontal Lobe Epilepsy) Full Gene Sequence Cox10 (Cox10 Homolog Cytochrome C Oxidase Assembly Protein) (Eg Mitochondrial Respiratory Chain Complex Iv Deficiency) Full Gene Sequence Cox15 (

Molecular Pathology Procedure Level 7 (Eg Analysis Of 11-25 Exons By Dna Sequence Analysis Mutation Scanning Or Duplication/Deletion Variants Of 26-50 Exons) Acadvl (Acyl-Coa Dehydrogenase Very Long Chain) (Eg Very Long Chain Acyl-Coenzyme A Dehydrogenase Deficiency) Full Gene Sequence Actn4 (Actinin Alpha 4) (Eg Focal Segmental Glomerulosclerosis) Full Gene Sequence Afg3L2 (Afg3 Atpase Family Gene 3-Like 2 [S. Cerevisiae]) (Eg Spinocerebellar Ataxia) Full Gene Sequence Aire (Autoimmune Regulator) (Eg Autoimmune Polyendocrinopathy Syndrome Type 1) Full Gene Sequence Aldh7A1 (Aldehyde Dehydrogenase 7 Family Member A1) (Eg Pyridoxine-Dependent Epilepsy) Full Gene Sequence Ano5 (Anoctamin 5) (Eg Limb-Girdle Muscular Dystrophy) Full Gene Sequence Anos1 (Anosmin-1) (Eg Kallmann Syndrome 1) Full Gene Sequence App (Amyloid Beta [A4] Precursor Protein) (Eg Alzheimer Disease) Full Gene Sequence Ass1 (Argininosuccinate Synthase 1) (Eg MP Criteria: Procedures/services reviewed against Medical Citrullinemia Type I) Full Gene Sequence Atl1 (Atlastin 81406 Policy Criteria. Submit for Recommended Clinical Review to Gtpase 1) (Eg Spastic Paraplegia) Full Gene Sequence avoid post-service review by Carelon. Atp1A2 (Atpase Na+/K+ Transporting Alpha 2 Polypeptide) (Eg Familial Hemiplegic Migraine) Full Gene Sequence Atp7B (Atpase Cu++ Transporting Beta Polypeptide) (Eg Wilson Disease) Full Gene Sequence Bbs1 (Bardet-Biedl Syndrome 1) (Eg Bardet-Biedl Syndrome) Full Gene Sequence Bbs2 (Bardet-Biedl Syndrome 2) (Eg Bardet-Biedl Syndrome) Full Gene Sequence Bckdhb (Branched-Chain Keto Acid Dehydrogenase E1 Beta Polypeptide) (Eg Maple Syrup Urine Disease Type 1B) Full Gene Sequence Best1 (Bestrophin 1) (Eg Vitelliform Macular Dystrophy) Full Gene Sequence Bmpr2 (Bone Morphogenetic Protein Receptor Type Ii [Serine/Threonine Kinase]) (Eg. Heritable Pulmonary Arterial Hypertension) Full Gene Sequence Braf (B-Raf Proto-Oncogene Serine/Threonine Kinase) (Eg Noonan Syndrome) Full Gene Sequence Bscl2 (Berardinelli-Seip Congenital Lipodystrophy 2 [Seipin]) (Eg Berardinelli-Seip Congenital Lipodystrophy) F

Molecular Pathology Procedure Level 8 (Eg Analysis Of 26-50 Exons By Dna Sequence Analysis Mutation Scanning Or Duplication/Deletion Variants Of >50 Exons Sequence Analysis Of Multiple Genes On One Platform) Abcc8 (Atp-Binding Cassette Sub-Family C [Cftr/Mrp] Member 8) (Eg Familial Hyperinsulinism) Full Gene Sequence Agl (Amylo-Alpha-1 6-Glucosidase 4-Alpha-Glucanotransferase) (Eg Glycogen Storage Disease Type Iii) Full Gene Sequence Ahi1 (Abelson Helper Integration Site 1) (Eg Joubert Syndrome) Full Gene Sequence Apob (Apolipoprotein B) (Eg Familial Hypercholesterolemia Type B) Full Gene Sequence Aspm (Asp [Abnormal Spindle] Homolog Microcephaly Associated [Drosophila]) (Eg Primary Microcephaly) Full Gene Sequence Chd7 (Chromodomain Helicase Dna Binding Protein 7) (Eg Charge Syndrome) Full Gene Sequence Col4A4 (Collagen Type Iv Alpha 4) (Eg Alport Syndrome) Full Gene Sequence Col4A5 (Collagen Type Iv Alpha 5) (Eg MP Criteria: Procedures/services reviewed against Medical Alport Syndrome) Duplication/Deletion Analysis Col6A1 81407 Policy Criteria. Submit for Recommended Clinical Review to (Collagen Type Vi Alpha 1) (Eg Collagen Type Vi-Related avoid post-service review by Carelon. Disorders) Full Gene Sequence Col6A2 (Collagen Type Vi Alpha 2) (Eg Collagen Type Vi-Related Disorders) Full Gene Sequence Col6A3 (Collagen Type Vi Alpha 3) (Eg Collagen Type Vi-Related Disorders) Full Gene Sequence Crebbp (Creb Binding Protein) (Eg Rubinstein-Taybi Syndrome) Full Gene Sequence F8 (Coagulation Factor Viii) (Eg Hemophilia A) Full Gene Sequence Jag1 (Jagged 1) (Eg Alagille Syndrome) Full Gene Sequence Kdm5C (Lysine Demethylase 5C) (Eg X-Linked Intellectual Disability) Full Gene Sequence Kiaa0196 (Kiaa0196) (Eg. Spastic Paraplegia) Full Gene Sequence L1Cam (L1 Cell Adhesion Molecule) (Eg. Masa Syndrome X-Linked Hydrocephaly) Full Gene Sequence Lamb2 (Laminin Beta 2 [Laminin S]) (Eg Pierson Syndrome) Full Gene Sequence Mybpc3 (Myosin Binding Protein C Cardiac) (Eg Familial Hypertrophic Cardiomyopathy) Full Gene Sequence Myh6 (Myosin Heavy Chain 6 Cardiac Muscle Alpha) (Eg Fam

	Molecular Pathology Procedure Level 9 (Eg Analysis Of >50				
	Exons In A Single Gene By Dna Sequence Analysis) Abca4				
	(Atp-Binding Cassette Sub-Family A [Abc1] Member 4) (Eg				
	Stargardt Disease Age-Related Macular Degeneration) Full				
	Gene Sequence Atm (Ataxia Telangiectasia Mutated) (Eg				
	Ataxia Telangiectasia) Full Gene Sequence Cdh23 (Cadherin-				
	Related 23) (Eg Usher Syndrome Type 1) Full Gene				
	Sequence Cep290 (Centrosomal Protein 290Kda) (Eg				
	Joubert Syndrome) Full Gene Sequence Col1A1 (Collagen				
	Type I Alpha 1) (Eg Osteogenesis Imperfecta Type I) Full				
	Gene Sequence Col1A2 (Collagen Type I Alpha 2) (Eg				
	Osteogenesis Imperfecta Type I) Full Gene Sequence				
	Col4A1 (Collagen Type Iv Alpha 1) (Eg Brain Small-Vessel				
	Disease With Hemorrhage) Full Gene Sequence Col4A3				
	(Collagen Type Iv Alpha 3 [Goodpasture Antigen]) (Eg				
	Alport Syndrome) Full Gene Sequence Col4A5 (Collagen				
	Type Iv Alpha 5) (Eg Alport Syndrome) Full Gene Sequence				
	Dmd (Dystrophin) (Eg Duchenne/Becker Muscular MP	P Criteria: Procedures/services reviewed against Medical			
81408	Dystrophy) Full Gene Sequence Dysf (Dysferlin Limb Girdle Pol	olicy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Muscular Dystrophy 2B [Autosomal Recessive]) (Eg Limb-avo	oid post-service review by Carelon.			
	Girdle Muscular Dystrophy) Full Gene Sequence Fbn1				
	(Fibrillin 1) (Eg Marfan Syndrome) Full Gene Sequence Itpr1				
	(Inositol 1 4 5-Trisphosphate Receptor Type 1) (Eg				
	Spinocerebellar Ataxia) Full Gene Sequence Lama2 (Laminin				
	Alpha 2) (Eg Congenital Muscular Dystrophy) Full Gene				
	Sequence Lrrk2 (Leucine-Rich Repeat Kinase 2) (Eg				
	Parkinson Disease) Full Gene Sequence Myh11 (Myosin				
	Heavy Chain 11 Smooth Muscle) (Eg Thoracic Aortic				
	Aneurysms And Aortic Dissections) Full Gene Sequence Neb				
	(Nebulin) (Eg Nemaline Myopathy 2) Full Gene Sequence				
	Nf1 (Neurofibromin 1) (Eg Neurofibromatosis Type 1) Full				
	Gene Sequence Pkhd1 (Polycystic Kidney And Hepatic				
	Disease 1) (Eg Autosomal Recessive Polycystic Kidney				
	Disease) Full Gene Sequence Ryr1 (Ryanodine Receptor 1				
	Skeletal) (Eg Malignant Hyperthermia) Full Gene Sequence				
	Ryr2 (Ryanodine Receptor 2 [Cardiac]) (Eg. Cate				
	Aortic Dysfunction Or Dilation (Eg. Marfan Syndrome Loeys				
	Dietz Syndrome, Ehler Danlos Syndrome Tyne Iv, Arterial	D. Cuitania. Duagada uras/aan ilaan urasia aada aasi sat 8.4 adi sat			
01.410	Tortuosity Syndrome): Genomic Sequence Analysis Panel	P Criteria: Procedures/services reviewed against Medical			
81410	Must Include Sequencing Of At Least 9 Genes Including	olicy Criteria. Submit for Recommended Clinical Review to	_	-	-
	Fbn1 Tgfbr1 Tgfbr2 Col3A1 Myh11 Acta2 Slc2A10 Smad3	oid post-service review by Carelon.			
	And Mylk				

			I		
81411	Aortic Dysfunction Or Dilation (Eg Marfan Syndrome Loeys Dietz Syndrome Ehler Danlos Syndrome Type Iv Arterial	MP Criteria: Procedures/services reviewed against Medical			
	Tortuosity Syndrome); Duplication/Deletion Analysis Panel	Policy Criteria. Submit for Recommended Clinical Review to			
		·	_	-	-
	Must Include Analyses For Tgfbr1 Tgfbr2 Myh11 And Col3A1	avoid post-service review by Carelon.			
	Ashkenazi Jewish Associated Disorders (Eg Bloom Syndrome				
	Canavan Disease Cystic Fibrosis Familial Dysautonomia				
	Fanconi Anemia Group C Gaucher Disease Tay-Sachs	MP Criteria: Procedures/services reviewed against Medical			
81412	Disease) Genomic Sequence Analysis Panel Must Include	Policy Criteria. Submit for Recommended Clinical Review to			
	Sequencing Of At Least 9 Genes Including Aspa Blm Cftr	avoid post-service review by Carelon.	_		
	Fancc Gba Hexa Ikbkap Mcoln1 And Smpd1	·			
	Cardiac Ion Channelopathies (Eg Brugada Syndrome Long				
	Qt Syndrome Short Qt Syndrome Catecholaminergic				
	Polymorphic Ventricular Tachycardia); Genomic Sequence	MP Criteria: Procedures/services reviewed against Medical			
81413	Analysis Panel Must Include Sequencing Of At Least 10	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Genes Including Ank2 Casq2 Cav3 Kcne1 Kcne2 Kcnh2	avoid post-service review by Carelon.			
	Kcnj2 Kcng1 Rvr2 And Scn5A				
	Cardiac Ion Channelopathies (Eg Brugada Syndrome Long				
	Qt Syndrome Short Qt Syndrome Catecholaminergic	MP Criteria: Procedures/services reviewed against Medical			
81414	Polymorphic Ventricular Tachycardia); Duplication/Deletion	Policy Criteria. Submit for Recommended Clinical Review to			
02.12.	Gene Analysis Panel Must Include Analysis Of At Least 2	avoid post-service review by Carelon.	_	_	-
	Genes Including Kcnh2 And Kcng1	avoid post service review by edicion.			
	Exome (Eg Unexplained Constitutional Or Heritable Disorder	MP Criteria: Procedures/services reviewed against Medical			
81415	Or Syndrome); Sequence Analysis	Policy Criteria. Submit for Recommended Clinical Review to			
	or syndromery sequence randrysis	avoid post-service review by Carelon.	_	_	_
	Exome (Eg Unexplained Constitutional Or Heritable Disorder	MP Criteria: Procedures/services reviewed against Medical			
81416	Or Syndrome); Sequence Analysis Each Comparator Exome	Policy Criteria. Submit for Recommended Clinical Review to			
01410	(Eg Parents Siblings) (List Separately In Addition To Code	avoid post-service review by Carelon.	_	-	_
	For Primary Procedure)	· ·			
	Exome (Eg Unexplained Constitutional Or Heritable Disorder	MP Criteria: Procedures/services reviewed against Medical			
81417	Or Syndrome); Re-Evaluation Of Previously Obtained Exome	Policy Criteria. Submit for Recommended Clinical Review to			
	Sequence (Eg Updated Knowledge Or Unrelated	avoid post-service review by Carelon.	_	_	_
	Condition/Syndrome)	,, 			
	Drug Metabolism (Eg Pharmacogenomics) Genomic	MP Criteria: Procedures/services reviewed against Medical			
81418	Sequence Analysis Panel Must Include Testing Of At Least 6	Policy Criteria. Submit for Recommended Clinical Review to			
	Genes Including Cyp2C19 Cyp2D6 And Cyp2D6	avoid post-service review by Carelon.	_		_
	Duplication/Deletion Analysis	<u>'</u>			
	Epilepsy Genomic Sequence Analysis Panel Must Include				
81419	Analyses For Aldh7A1 Cacna1A Cdkl5 Chd2 Gabrg2	MP Criteria: Procedures/services reviewed against Medical			
	Grin2A Kcnq2 Mecp2 Pcdh19 Polg Prrt2 Scn1A Scn1B	Policy Criteria. Submit for Recommended Clinical Review to	-	_	-
	Scn2A Scn8A Slc2A1 Slc9A6 Stxbp1 Syngap1 Tcf4 Tpp1	avoid post-service review by Carelon.			
	Tsc1 Tsc2 And Zeb2				-
	Fetal Chromosomal Microdeletion(S) Genomic Sequence	MP Criteria: Procedures/services reviewed against Medical			
81422	Analysis (Eg Digeorge Syndrome Cri-Du-Chat Syndrome)	Policy Criteria. Submit for Recommended Clinical Review to	-	_	-
	Circulating Cell-Free Fetal Dna In Maternal Blood	avoid post-service review by Carelon.			ļ

81425	Genome (Eg Unexplained Constitutional Or Heritable Disorder Or Syndrome); Sequence Analysis	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	-	-
81426	Genome (Eg Unexplained Constitutional Or Heritable Disorder Or Syndrome); Sequence Analysis Each Comparator Genome (Eg Parents Siblings) (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
81427	Genome (Eg Unexplained Constitutional Or Heritable Disorder Or Syndrome); Re-Evaluation Of Previously Obtained Genome Sequence (Eg Updated Knowledge Or Unrelated Condition/Syndrome)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
81430	Hearing Loss (Eg Nonsyndromic Hearing Loss Usher Syndrome Pendred Syndrome); Genomic Sequence Analysis Panel Must Include Sequencing Of At Least 60 Genes Including Cdh23 Clrn1 Gjb2 Gpr98 Mtrnr1 Myo7A Myo15A Pcdh15 Otof Slc26A4 Tmc1 Tmprss3 Ush1C Ush1G Ush2A And Wfs1	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
81431	Hearing Loss (Eg Nonsyndromic Hearing Loss Usher Syndrome Pendred Syndrome); Duplication/Deletion Analysis Panel Must Include Copy Number Analyses For Strc And Dfnb1 Deletions In Gjb2 And Gjb6 Genes	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
81432	Hereditary Breast Cancer-Related Disorders (Eg Hereditary Breast Cancer Hereditary Ovarian Cancer Hereditary Endometrial Cancer); Genomic Sequence Analysis Panel Must Include Sequencing Of At Least 10 Genes Always Including Brca1 Brca2 Cdh1 Mlh1 Msh2 Msh6 Palb2 Pten Stk11 And Tp53	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	_
81433	Hereditary Breast Cancer-Related Disorders (Eg Hereditary Breast Cancer Hereditary Ovarian Cancer Hereditary Endometrial Cancer); Duplication/Deletion Analysis Panel Must Include Analyses For Brca1 Brca2 Mlh1 Msh2 And Stk11	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
81434	Hereditary Retinal Disorders (Eg Retinitis Pigmentosa Leber Congenital Amaurosis Cone-Rod Dystrophy) Genomic Sequence Analysis Panel Must Include Sequencing Of At Least 15 Genes Including Abca4 Cnga1 Crb1 Eys Pde6A Pde6B Prpf31 Prph2 Rdh12 Rho Rp1 Rp2 Rpe65 Rpgr And Ush2A	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
81435	Hereditary Colon Cancer Disorders (Eg Lynch Syndrome Pten Hamartoma Syndrome Cowden Syndrome Familial Adenomatosis Polyposis); Genomic Sequence Analysis Panel Must Include Sequencing Of At Least 10 Genes Including Apc Bmpr1A Cdh1 Mlh1 Msh2 Msh6 Mutyh Pten Smad4 And Stk11	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-

81436	Hereditary Colon Cancer Disorders (Eg Lynch Syndrome Pten Hamartoma Syndrome Cowden Syndrome Familial Adenomatosis Polyposis); Duplication/Deletion Analysis Panel Must Include Analysis Of At Least 5 Genes Including Mlh1 Msh2 Epcam Smad4 And Stk11	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
81437	Hereditary Neuroendocrine Tumor Disorders (Eg Medullary Thyroid Carcinoma Parathyroid Carcinoma Malignant Pheochromocytoma Or Paraganglioma); Genomic Sequence Analysis Panel Must Include Sequencing Of At Least 6 Genes Including Max Sdhb Sdhc Sdhd Tmem127 And Vhl	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	-	_
81438	Hereditary Neuroendocrine Tumor Disorders (Eg Medullary Thyroid Carcinoma Parathyroid Carcinoma Malignant Pheochromocytoma Or Paraganglioma); Duplication/Deletion Analysis Panel Must Include Analyses For Sdhb Sdhc Sdhd And Vhl	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
81439	Hereditary Cardiomyopathy (Eg Hypertrophic Cardiomyopathy Dilated Cardiomyopathy Arrhythmogenic Right Ventricular Cardiomyopathy) Genomic Sequence Analysis Panel Must Include Sequencing Of At Least 5 Cardiomyopathy-Related Genes (Eg Dsg2 Mybpc3 Myh7 Pkp2 Ttn)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
81440	Nuclear Encoded Mitochondrial Genes (Eg Neurologic Or Myopathic Phenotypes) Genomic Sequence Panel Must Include Analysis Of At Least 100 Genes Including Bcs1L C10Orf2 Coq2 Cox10 Dguok Mpv17 Opa1 Pdss2 Polg Polg2 Rrm2B Sco1 Sco2 Slc25A4 Sucla2 Suclg1 Taz Tk2 And Tymp	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
81441	Inherited Bone Marrow Failure Syndromes (Ibmfs) (Eg Fanconi Anemia Dyskeratosis Congenita Diamond-Blackfan Anemia Shwachman-Diamond Syndrome Gata2 Deficiency Syndrome Congenital Amegakaryocytic Thrombocytopenia) Sequence Analysis Panel Must Include Sequencing Of At Least 30 Genes Including Brca2 Brip1 Dkc1 Fanca Fancb Fancc Fancd2 Fance Fancf Fancg Fanci Fancl Gata1 Gata2 Mpl Nhp2 Nop10 Palb2 Rad51C Rpl11 Rpl35A Rpl5 Rps10 Rps19 Rps24 Rps26 Rps7 Sbds Tert And Tinf2	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	-	_
81442	Noonan Spectrum Disorders (Eg Noonan Syndrome Cardio-Facio-Cutaneous Syndrome Costello Syndrome Leopard Syndrome Noonan-Like Syndrome) Genomic Sequence Analysis Panel Must Include Sequencing Of At Least 12 Genes Including Braf Cbl Hras Kras Map2K1 Map2K2 Nras Ptpn11 Raf1 Rit1 Shoc2 And Sos1	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-

81443	Genetic Testing For Severe Inherited Conditions (Eg Cystic Fibrosis Ashkenazi Jewish-Associated Disorders [Eg Bloom Syndrome Canavan Disease Fanconi Anemia Type C Mucolipidosis Type Vi Gaucher Disease Tay-Sachs Disease] Beta Hemoglobinopathies Phenylketonuria Galactosemia) Genomic Sequence Analysis Panel Must Include Sequencing Of At Least 15 Genes (Eg Acadm Arsa Aspa Atp7B Bckdha Bckdhb Blm Cftr Dhcr7 Fancc G6Pc Gaa Galt Gba Gbe1 Hbb Hexa Ikbkap Mcoln1 Pah)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
81445	Solid Organ Neoplasm Genomic Sequence Analysis Panel 5- 50 Genes Interrogation For Sequence Variants And Copy Number Variants Or Rearrangements If Performed; Dna Analysis Or Combined Dna And Rna Analysis	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
81448	Hereditary Peripheral Neuropathies (Eg Charcot-Marie- Tooth Spastic Paraplegia) Genomic Sequence Analysis Panel Must Include Sequencing Of At Least 5 Peripheral Neuropathy-Related Genes (Eg Bscl2 Gjb1 Mfn2 Mpz Reep1 Spast Spg11 Sptlc1)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
81449	Solid Organ Neoplasm Genomic Sequence Analysis Panel 5- 50 Genes Interrogation For Sequence Variants And Copy Number Variants Or Rearrangements If Performed; Rna Analysis	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
81450	Hematolymphoid Neoplasm Or Disorder Genomic Sequence Analysis Panel 5-50 Genes Interrogation For Sequence Variants And Copy Number Variants Or Rearrangements Or Isoform Expression Or Mrna Expression Levels If Performed; Dna Analysis Or Combined Dna And Rna Analysis	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	_
81451	Hematolymphoid Neoplasm Or Disorder Genomic Sequence Analysis Panel 5-50 Genes Interrogation For Sequence Variants And Copy Number Variants Or Rearrangements Or Isoform Expression Or Mrna Expression Levels If Performed; Rna Analysis	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
81455	Solid Organ Or Hematolymphoid Neoplasm Or Disorder 51 Or Greater Genes Genomic Sequence Analysis Panel Interrogation For Sequence Variants And Copy Number Variants Or Rearrangements Or Isoform Expression Or Mrna Expression Levels If Performed; Dna Analysis Or Combined Dna And Rna Analysis	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
81456	Solid Organ Or Hematolymphoid Neoplasm Or Disorder 51 Or Greater Genes Genomic Sequence Analysis Panel Interrogation For Sequence Variants And Copy Number Variants Or Rearrangements Or Isoform Expression Or Mrna Expression Levels If Performed; Rna Analysis	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-

81460	Whole Mitochondrial Genome (Eg Leigh Syndrome Mitochondrial Encephalomyopathy Lactic Acidosis And Stroke-Like Episodes [Melas] Myoclonic Epilepsy With Ragged-Red Fibers [Merff] Neuropathy Ataxia And Retinitis Pigmentosa [Narp] Leber Hereditary Optic Neuropathy [Lhon]) Genomic Sequence Must Include Sequence Analysis Of Entire Mitochondrial Genome With Heteroplasmy	avoid post-service review by Carelon.	-	_	-
81465	Detection Whole Mitochondrial Genome Large Deletion Analysis Panel (Eg Kearns-Sayre Syndrome Chronic Progressive External Ophthalmoplegia) Including Heteroplasmy Detection If Performed	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
81470	X-Linked Intellectual Disability (Xlid) (Eg Syndromic And Non- Syndromic Xlid); Genomic Sequence Analysis Panel Must Include Sequencing Of At Least 60 Genes Including Arx Atrx Cdkl5 Fgd1 Fmr1 Huwe1 Il1Rapl Kdm5C L1Cam Mecp2 Med12 Mid1 Ocrl Rps6Ka3 And Slc16A2	MP Criteria: Procedures/services reviewed against Medical	-	-	-
81471	X-Linked Intellectual Disability (Xlid) (Eg Syndromic And Non- Syndromic Xlid); Duplication/Deletion Gene Analysis Must Include Analysis Of At Least 60 Genes Including Arx Atrx Cdkl5 Fgd1 Fmr1 Huwe1 Il1Rapl Kdm5C L1Cam Mecp2 Med12 Mid1 Ocrl Rps6Ka3 And Slc16A2	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
81479	Unlisted Molecular Pathology Procedure	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	-	-	-
81493	Coronary Artery Disease Mrna Gene Expression Profiling By Real-Time Rt-Pcr Of 23 Genes Utilizing Whole Peripheral Blood Algorithm Reported As A Risk Score	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
81504	Oncology (Tissue Of Origin) Microarray Gene Expression Profiling Of > 2000 Genes Utilizing Formalin-Fixed Paraffin- Embedded Tissue Algorithm Reported As Tissue Similarity Scores	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
81518	Oncology (Breast) Mrna Gene Expression Profiling By Real- Time Rt-Pcr Of 11 Genes (7 Content And 4 Housekeeping) Utilizing Formalin-Fixed Paraffin-Embedded Tissue Algorithms Reported As Percentage Risk For Metastatic Recurrence And Likelihood Of Benefit From Extended Endocrine Therapy	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	_	_
81519	Oncology (Breast) Mrna Gene Expression Profiling By Real- Time Rt-Pcr Of 21 Genes Utilizing Formalin-Fixed Paraffin- Embedded Tissue Algorithm Reported As Recurrence Score	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-

81520	Oncology (Breast) Mrna Gene Expression Profiling By Hybrid Capture Of 58 Genes (50 Content And 8 Housekeeping) Utilizing Formalin-Fixed Paraffin-Embedded Tissue Algorithm Reported As A Recurrence Risk Score	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
81521	Oncology (Breast) Mrna Microarray Gene Expression Profiling Of 70 Content Genes And 465 Housekeeping Genes Utilizing Fresh Frozen Or Formalin-Fixed Paraffin-Embedded Tissue Algorithm Reported As Index Related To Risk Of Distant Metastasis	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
81522	Oncology (Breast) Mrna Gene Expression Profiling By Rt-Pcr Of 12 Genes (8 Content And 4 Housekeeping) Utilizing Formalin-Fixed Paraffin-Embedded Tissue Algorithm Reported As Recurrence Risk Score	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
81523	Oncology (Breast) Mrna Next-Generation Sequencing Gene Expression Profiling Of 70 Content Genes And 31 Housekeeping Genes Utilizing Formalin-Fixed Paraffin-Embedded Tissue Algorithm Reported As Index Related To Risk To Distant Metastasis	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
81525	Oncology (Colon) Mrna Gene Expression Profiling By Real- Time Rt-Pcr Of 12 Genes (7 Content And 5 Housekeeping) Utilizing Formalin-Fixed Paraffin-Embedded Tissue Algorithm Reported As A Recurrence Score	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	-	_
81529	Oncology (Cutaneous Melanoma) Mrna Gene Expression Profiling By Real-Time Rt-Pcr Of 31 Genes (28 Content And 3 Housekeeping) Utilizing Formalin-Fixed Paraffin-Embedded Tissue Algorithm Reported As Recurrence Risk Including Likelihood Of Sentinel Lymph Node Metastasis	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
81540	Oncology (Tumor Of Unknown Origin) Mrna Gene Expression Profiling By Real-Time Rt-Pcr Of 92 Genes (87 Content And 5 Housekeeping) To Classify Tumor Into Main Cancer Type And Subtype Utilizing Formalin-Fixed Paraffin- Embedded Tissue Algorithm Reported As A Probability Of A Predicted Main Cancer Type And Subtype	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	_
81541	Oncology (Prostate) Mrna Gene Expression Profiling By Real- Time Rt-Pcr Of 46 Genes (31 Content And 15 Housekeeping) Utilizing Formalin-Fixed Paraffin-Embedded Tissue Algorithm Reported As A Disease-Specific Mortality Risk Score	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
81542	Oncology (Prostate) Mrna Microarray Gene Expression Profiling Of 22 Content Genes Utilizing Formalin-Fixed Paraffin-Embedded Tissue Algorithm Reported As Metastasis Risk Score	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-

81546	Oncology (Thyroid) Mrna Gene Expression Analysis Of 10 196 Genes Utilizing Fine Needle Aspirate Algorithm Reported As A Categorical Result (Eg Benign Or Suspicious)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	-	-
81551	Oncology (Prostate) Promoter Methylation Profiling By Real- Time Pcr Of 3 Genes (Gstp1 Apc Rassf1) Utilizing Formalin- Fixed Paraffin-Embedded Tissue Algorithm Reported As A Likelihood Of Prostate Cancer Detection On Repeat Biopsy	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
81552	Oncology (Uveal Melanoma) Mrna Gene Expression Profiling By Real-Time Rt-Pcr Of 15 Genes (12 Content And 3 Housekeeping) Utilizing Fine Needle Aspirate Or Formalin- Fixed Paraffin-Embedded Tissue Algorithm Reported As Risk Of Metastasis	Policy Criteria. Submit for Recommended Clinical Review to	-	-	-
81554	Pulmonary Disease (Idiopathic Pulmonary Fibrosis [Ipf]) Mrna Gene Expression Analysis Of 190 Genes Utilizing Transbronchial Biopsies Diagnostic Algorithm Reported As Categorical Result (Eg Positive Or Negative For High Probability Of Usual Interstitial Pneumonia [Uip])	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
81595	Cardiology (Heart Transplant) Mrna Gene Expression Profiling By Real-Time Quantitative Pcr Of 20 Genes (11 Content And 9 Housekeeping) Utilizing Subfraction Of Peripheral Blood Algorithm Reported As A Rejection Risk Score	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
81599	Unlisted Multianalyte Assay With Algorithmic Analysis	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
82523	Collagen Cross Links Any Method	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
83006	Growth Stimulation Expressed Gene 2 (St2 Interleukin 1 Receptor Like-1)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	-	-	-
83695	Lipoprotein (A)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	-	-
83698	Lipoprotein-Associated Phospholipase A2 (Lp-Pla2)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	-	-
83701	Lipoprotein Blood; High Resolution Fractionation And Quantitation Of Lipoproteins Including Lipoprotein Subclasses When Performed (Eg Electrophoresis Ultracentrifugation)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
83704	Lipoprotein Blood; Quantitation Of Lipoprotein Particle Number(S) (Eg By Nuclear Magnetic Resonance Spectroscopy) Includes Lipoprotein Particle Subclass(Es) When Performed	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	-

	Lipoprotein Direct Measurement; Small Dense Ldl	EIU: Procedure/service not reimbursed by the Plan. Not			
83722	Cholesterol	subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Osteocalcin (Bone G1A Protein)	EIU: Procedure/service not reimbursed by the Plan. Not			
83937	· · · · · · · · · · · · · · · · · · ·	subject to pre-service review. Check EIU policy, which is			
		one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
	Ph; Exhaled Breath Condensate	EIU: Procedure/service not reimbursed by the Plan. Not			
83987	111, Extrated breath Condensate	subject to pre-service review. Check EIU policy, which is			
03307			-	-	-
	Enclosite Of Contract of Elith English Contract Association Elith	one of our Clinical Payment and Coding Policy (CPCP).			
	Evaluation Of Cervicovaginal Fluid For Specific Amniotic Fluid Protein(S) (Eg. Placental Alpha Microglobulin-1 [Pamg-1]	EIU: Procedure/service not reimbursed by the Plan. Not			
84112	· · · · · · · · · · · · · · · · · · ·	subject to pre-service review. Check EIU policy, which is			
	Placental Protein 12 [Pp12] Alpha-Fetoprotein) Qualitative	one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
	Each Specimen				
	Thromboxane Metabolite(S) Including Thromboxane If	EIU: Procedure/service not reimbursed by the Plan. Not			
84431	Performed Urine	subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
84999	Unlisted Chemistry Procedure	Unlisted: Procedure/service not specifically defined or			
04999		classified, maybe subject to contract/clinical review.	_	-	-
05000	Unlisted Hematology And Coagulation Procedure	Unlisted: Procedure/service not specifically defined or			
85999		classified, maybe subject to contract/clinical review.	-	-	-
	Allergen Specific Igg Quantitative Or Semiguantitative Each	EIU: Procedure/service not reimbursed by the Plan. Not			
86001	Allergen	subject to pre-service review. Check EIU policy, which is			
		one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
	Immunoassay For Infectious Agent Antibody(les) Qualitative				
	Or Semiquantitative Single-Step Method (Eg Reagent Strip);				
86328	Severe Acute Respiratory Syndrome Coronavirus 2 (Sars-Cov-				
00320		one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
	2) (Coronavirus Disease [Covid-19])	one of our chilical Payment and County Policy (CPCP).			
	Leukocyte Histamine Release Test (Lhr)	EIU: Procedure/service not reimbursed by the Plan. Not			
86343		subject to pre-service review. Check EIU policy, which is			
003 13		one of our Clinical Payment and Coding Policy (CPCP).	_	-	-
	Cellular Function Assay Involving Stimulation (Eg. Mitogen	MP Criteria: Procedure/service reviewed against Medical			
86352	, , , , , , , , , , , , , , , , , , , ,	Policy Criteria. Submit for Recommended Clinical Review to			
00552	Or Antigen) And Detection Of Biomarker (Eg Atp)	•	_	_	-
	Leading to Target and the Address (Dlates in the Address of Date and Date a	avoid post-service review.			
05050	Lymphocyte Transformation Mitogen (Phytomitogen) Or	MP Criteria: Procedure/service reviewed against Medical			
86353	Antigen Induced Blastogenesis	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Neutralizing Antibody Severe Acute Respiratory Syndrome	EIU: Procedure/service not reimbursed by the Plan. Not			
86408	Coronavirus 2 (Sars-Cov-2) (Coronavirus Disease [Covid-19]);	subject to pre-service review. Check EIU policy, which is	_	_	_
	Screen	one of our Clinical Payment and Coding Policy (CPCP).			
	Neutralizing Antibody Severe Acute Respiratory Syndrome	EIU: Procedure/service not reimbursed by the Plan. Not			
86409	Coronavirus 2 (Sars-Cov-2) (Coronavirus Disease [Covid-19]);	subject to pre-service review. Check EIU policy, which is	_	_	_
	Titer	one of our Clinical Payment and Coding Policy (CPCP).			
	Severe Acute Respiratory Syndrome Coronavirus 2 (Sars-Cov-				
86413	2) (Coronavirus Disease [Covid-19]) Antibody Quantitative	subject to pre-service review. Check EIU policy, which is			
	,,	one of our Clinical Payment and Coding Policy (CPCP).	_	_	
				•	

86486	Skin Test; Unlisted Antigen Each	Unlisted: Procedure/service not specifically defined or			
		classified, maybe subject to contract/clinical review.	_	-	-
	Antibody; Severe Acute Respiratory Syndrome Coronavirus 2	EIU: Procedure/service not reimbursed by the Plan. Not			
86769	(Sars-Cov-2) (Coronavirus Disease [Covid-19])	subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
00040	Unlisted Immunology Procedure	Unlisted: Procedure/service not specifically defined or			
86849	5.	classified, maybe subject to contract/clinical review.	-	-	-
	Blood Typing For Paternity Testing Per Individual; Abo Rh	Non Covered: Procedure/service not covered by the Plan.			
86910	And Mn	Not subject to pre-service review.	_	_	_
	Blood Typing For Paternity Testing Per Individual; Each	Non Covered: Procedure/service not covered by the Plan.			
86911	Additional Antigen System	Not subject to pre-service review.	_	_	_
	Leukocyte Transfusion	MP Criteria: Procedure/service reviewed against Medical			
86950	Leukocyte Halisiusion	Policy Criteria. Submit for Recommended Clinical Review to			
80930		•	_	-	_
	Unlisted Transfusion Medicine Durandura	avoid post-service review.			
86999	Unlisted Transfusion Medicine Procedure	Unlisted: Procedure/service not specifically defined or	_	_	_
		classified, maybe subject to contract/clinical review.			
	Infectious Agent Detection By Nucleic Acid (Dna Or Rna);				
	Gastrointestinal Pathogen (Eg Clostridium Difficile E. Coli	MP Criteria: Procedure/service reviewed against Medical			
87505	Salmonella Shigella Norovirus Giardia) Includes Multiplex	Policy Criteria. Submit for Recommended Clinical Review to			
0,000	Reverse Transcription When Performed And Multiplex	avoid post-service review.	_	_	_
	Amplified Probe Technique Multiple Types Or Subtypes 3-5				
	Targets				
	Infectious Agent Detection By Nucleic Acid (Dna Or Rna);	avoid post-service review.			
	Gastrointestinal Pathogen (Eg Clostridium Difficile E. Coli				
	Salmonella Shigella Norovirus Giardia) Includes Multiplex				
87506	Reverse Transcription When Performed And Multiplex		_	_	_
	Amplified Probe Technique Multiple Types Or Subtypes 6-				
	11 Targets				
	Infectious Agent Detection By Nucleic Acid (Dna Or Rna);				
	Gastrointestinal Pathogen (Eg Clostridium Difficile E. Coli	MP Criteria: Procedure/service reviewed against Medical			
87507	Salmonella Shigella Norovirus Giardia) Includes Multiplex	Policy Criteria. Submit for Recommended Clinical Review to	_		_
	Reverse Transcription When Performed And Multiplex	avoid post-service review.			
	Amplified Probe Technique Multiple Types Or Subtypes 12-				
	25 Targets				
	Infectious Agent Detection By Nucleic Acid (Dna Or Rna) Not	Unlisted: Procedure/service not specifically defined or			
87797	Otherwise Specified; Direct Probe Technique Each Organism	classified, maybe subject to contract/clinical review.	_	-	-
		2.2.2			
	Infectious Agent Detection By Nucleic Acid (Dna Or Rna) Not	Unlisted: Procedure/service not specifically defined or			
87798	Otherwise Specified; Amplified Probe Technique Each	classified, maybe subject to contract/clinical review.	_	_	_
	Organism	ciassifica, maybe subject to contract/cliffical feview.			
97700	Infectious Agent Detection By Nucleic Acid (Dna Or Rna) Not	Unlisted: Procedure/service not specifically defined or			
87799	Otherwise Specified; Quantification Each Organism	classified, maybe subject to contract/clinical review.	-	-	-
	Infectious Agent Antigen Detection By Immunoassay With				
87899	Direct Optical (le Visual) Observation; Not Otherwise	Unlisted: Procedure/service not specifically defined or			
	Specified	classified, maybe subject to contract/clinical review.	_		_
	Unlisted Microbiology Procedure	Unlisted: Procedure/service not specifically defined or			
87999	Similated Wild Obiology Frocedure	classified, maybe subject to contract/clinical review.	_	_	_
		classified, maybe subject to contract/cliffical review.			

88000	Necropsy (Autopsy) Gross Examination Only; Without Cns	Non Covered: Procedure/service not covered by the Plan.			
		Not subject to pre-service review.	-	-	_
88005	Necropsy (Autopsy) Gross Examination Only; With Brain	Non Covered: Procedure/service not covered by the Plan.			
		Not subject to pre-service review.	_	_	-
88007	Necropsy (Autopsy) Gross Examination Only; With Brain	Non Covered: Procedure/service not covered by the Plan.			
	And Spinal Cord	Not subject to pre-service review.	-	-	_
88012	Necropsy (Autopsy) Gross Examination Only; Infant With	Non Covered: Procedure/service not covered by the Plan.			
	Brain	Not subject to pre-service review.	-	-	_
88014	Necropsy (Autopsy) Gross Examination Only; Stillborn Or	Non Covered: Procedure/service not covered by the Plan.			
	Newborn With Brain	Not subject to pre-service review.	_	-	_
88016	Necropsy (Autopsy) Gross Examination Only; Macerated	Non Covered: Procedure/service not covered by the Plan.			
88010	Stillborn	Not subject to pre-service review.	_	_	_
88020	Necropsy (Autopsy) Gross And Microscopic; Without Cns	Non Covered: Procedure/service not covered by the Plan.			
88020		Not subject to pre-service review.	_	-	-
88035	Necropsy (Autopsy) Gross And Microscopic; With Brain	Non Covered: Procedure/service not covered by the Plan.			
88025		Not subject to pre-service review.	-	-	-
20027	Necropsy (Autopsy) Gross And Microscopic; With Brain And	Non Covered: Procedure/service not covered by the Plan.			
88027	Spinal Cord	Not subject to pre-service review.	_	-	_
	Necropsy (Autopsy) Gross And Microscopic; Infant With	Non Covered: Procedure/service not covered by the Plan.			
88028	Brain	Not subject to pre-service review.	_	_	_
	Necropsy (Autopsy) Gross And Microscopic; Stillborn Or	Non Covered: Procedure/service not covered by the Plan.			
88029	Newborn With Brain	Not subject to pre-service review.	_	_	_
	Necropsy (Autopsy) Limited Gross And/Or Microscopic;	Non Covered: Procedure/service not covered by the Plan.			
88036	Regional	Not subject to pre-service review.	_	_	_
	Necropsy (Autopsy) Limited Gross And/Or Microscopic;	Non Covered: Procedure/service not covered by the Plan.			
88037	Single Organ	Not subject to pre-service review.	_	_	_
	Necropsy (Autopsy); Forensic Examination	Non Covered: Procedure/service not covered by the Plan.			
88040		Not subject to pre-service review.	_	_	_
	Necropsy (Autopsy); Coroner'S Call	Non Covered: Procedure/service not covered by the Plan.			
88045	Treatops (tatops ()) continue of call	Not subject to pre-service review.	_	_	_
	Unlisted Necropsy (Autopsy) Procedure	Non Covered: Procedure/service not covered by the Plan.			
	Chilisted Necropsy (Natopsy) Procedure	Not subject to pre-service review.			
88099		Unlisted or Undefined: Procedures/services not specifically			
00033		defined or classified, maybe subject to contract/clinical	-	-	_
		review.			
	Unlisted Cytopathology Procedure	Unlisted: Procedure/service not specifically defined or			
88199	omisted cytopathology rioceddie	classified, maybe subject to contract/clinical review.	_	_	_
	Unlisted Cytogenetic Study	Unlisted: Procedure/service not specifically defined or			
88299	omisted Cytogenetic Study		_	_	_
	Optical Endomicroscopic Image(S) Interpretation And	classified, maybe subject to contract/clinical review. EIU: Procedure/service not reimbursed by the Plan. Not			
88375		subject to pre-service review. Check EIU policy, which is			
003/3	Report Real-Time Or Referred Each Endoscopic Session		_	_	_
	Unlisted Surgical Pathology Presedure	one of our Clinical Payment and Coding Policy (CPCP).			
88399	Unlisted Surgical Pathology Procedure	Unlisted: Procedure/service not specifically defined or	_	_	_
	Unlisted in Vivo (For Transquitarians) Laboratory Constru	classified, maybe subject to contract/clinical review.			
88749	Unlisted In Vivo (Eg Transcutaneous) Laboratory Service	Unlisted: Procedure/service not specifically defined or			_
		classified, maybe subject to contract/clinical review.			

89240	Unlisted Miscellaneous Pathology Test	Unlisted: Procedure/service not specifically defined or			
89240		classified, maybe subject to contract/clinical review.	_	-	_
89258	Cryopreservation; Embryo(S)	Non Covered: Procedure/service not covered by the Plan.			Retire effective
09230		Not subject to pre-service review.		4/23/2024	4/23/2024
	Cryopreservation; Embryo(S)	MP Criteria: Procedure/service reviewed against Medical			
89258		Policy Criteria. Submit for Recommended Clinical Review to			Effective
		avoid post-service review.	4/24/2024		4/24/2024
	Cryopreservation; Sperm	MP Criteria: Procedure/service reviewed against Medical			
89259		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Cryopreservation Reproductive Tissue Testicular	MP Criteria: Procedure/service reviewed against Medical			
89335		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Cryopreservation Mature Oocyte(S)	MP Criteria: Procedure/service reviewed against Medical			
89337		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Storage (Per Year); Embryo(S)	MP Criteria: Procedure/service reviewed against Medical			
89342		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Storage (Per Year); Sperm/Semen	MP Criteria: Procedure/service reviewed against Medical			
89343		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Storage (Per Year); Reproductive Tissue Testicular/Ovarian	MP Criteria: Procedure/service reviewed against Medical			
89344		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
89346	Storage (Per Year); Oocyte(S)	Non Covered: Procedure/service not covered by the Plan.			Retire effective
09540		Not subject to pre-service review.		4/23/2024	4/23/2024
	Storage (Per Year); Oocyte(S)	MP Criteria: Procedure/service reviewed against Medical			
89346		Policy Criteria. Submit for Recommended Clinical Review to			Effective
		avoid post-service review.	4/24/2024		4/24/2024
89398	Unlisted Reproductive Medicine Laboratory Procedure	Unlisted: Procedure/service not specifically defined or			
03330		classified, maybe subject to contract/clinical review.	-	-	_
	Respiratory Syncytial Virus Monoclonal Antibody	MP Criteria: Procedure/service reviewed against Medical			
90378	Recombinant For Intramuscular Use 50 Mg Each	Policy Criteria. Submit for Recommended Clinical Review to			
90376		avoid post-service review. Prior Authorization may be	_	-	_
		required per contract agreement.			
90399	Unlisted Immune Globulin	Unlisted: Procedure/service not specifically defined or			
90599		classified, maybe subject to contract/clinical review.	_	-	_
90584	Dengue Vaccine Quadrivalent Live 2 Dose Schedule For	Non Covered: Procedure/service not covered by the Plan.			
JUJ04	Subcutaneous Use	Not subject to pre-service review.	-	-	_
	Influenza Virus Vaccine Quadrivalent (liv4) Inactivated	Non Covered: Procedure/service not covered by the Plan.			
90689	Adjuvanted Preservative Free 0.25 MI Dosage For	· ·	_	_	_
	Intramuscular Use	Not subject to pre-service review.			
00740	Unlisted Vaccine/Toxoid	Unlisted: Procedure/service not specifically defined or			
90749		classified, maybe subject to contract/clinical review.	-	_	-

	Therapeutic Repetitive Transcranial Magnetic Stimulation	MP Criteria: Procedure/service reviewed against Medical			
00067	(Tms) Treatment; Initial Including Cortical Mapping Motor				
90867	Threshold Determination Delivery And Management	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Therapeutic Repetitive Transcranial Magnetic Stimulation	MP Criteria: Procedure/service reviewed against Medical			
90868	(Tms) Treatment; Subsequent Delivery And Management	Policy Criteria. Submit for Recommended Clinical Review to			_
	Per Session	avoid post-service review.			
	Therapeutic Repetitive Transcranial Magnetic Stimulation	MP Criteria: Procedure/service reviewed against Medical			
90869	(Tms) Treatment; Subsequent Motor Threshold Re-	Policy Criteria. Submit for Recommended Clinical Review to			
	Determination With Delivery And Management	avoid post-service review.	_	_	_
	Individual Psychophysiological Therapy Incorporating	avoia post service review.			
	, , , , , , , , , , , , , , , , , , , ,	MP Criteria: Procedure/service reviewed against Medical			
90875	Biofeedback Training By Any Modality (Face-To-Face With	·			
90875	The Patient) With Psychotherapy (Eg Insight Oriented	Policy Criteria. Submit for Recommended Clinical Review to	_	-	-
	Behavior Modifying Or Supportive Psychotherapy); 30	avoid post-service review.			
	Minutes				
	Individual Psychophysiological Therapy Incorporating				
	Biofeedback Training By Any Modality (Face-To-Face With	MP Criteria: Procedure/service reviewed against Medical			
90876	The Patient) With Psychotherapy (Eg Insight Oriented	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Behavior Modifying Or Supportive Psychotherapy); 45	avoid post-service review.			
	Minutes				
	Hypnotherapy	MP Criteria: Procedure/service reviewed against Medical			
90880		Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review.	_	5/31/2024	Retire effective 5/31/2024
	Psychiatric Evaluation Of Hospital Records Other Psychiatric				
	Reports Psychometric And/Or Projective Tests And Other	Non Covered: Procedure/service not covered by the Plan.			
90885	Accumulated Data For Medical Diagnostic Purposes	Not subject to pre-service review.	_	_	_
	Accumulated Data For Medical Diagnostic Fulposes	not subject to pre service review.			
	Preparation Of Report Of Patient'S Psychiatric Status History				
	Treatment Or Progress (Other Than For Legal Or	Non Covered: Procedure/service not covered by the Plan.			
90889	Consultative Purposes) For Other Individuals Agencies Or	Not subject to pre-service review.	_	_	_
	Insurance Carriers	,			
	Unlisted Psychiatric Service Or Procedure	Unlisted: Procedure/service not specifically defined or			
90899	omisted rayonatric service of riocedure	classified, maybe subject to contract/clinical review.	_	_	_
	Biofeedback Training By Any Modality	MP Criteria: Procedure/service reviewed against Medical			
90901	bioleeaback frailing by Arry Wodanty	Policy Criteria. Submit for Recommended Clinical Review to			
50501		avoid post-service review.	-	-	_
	Biofeedback Training Perineal Muscles Anorectal Or	avoid post-service review.			
		MP Criteria: Procedure/service reviewed against Medical			
00013	Urethral Sphincter Including Emg And/Or Manometry				
90912	When Performed; Initial 15 Minutes Of One-On-One	Policy Criteria. Submit for Recommended Clinical Review to	_	-	-
	Physician Or Other Qualified Health Care Professional	avoid post-service review.			
	Contact With The Patient				
	Biofeedback Training Perineal Muscles Anorectal Or				
	Urethral Sphincter Including Emg And/Or Manometry	MP Criteria: Procedure/service reviewed against Medical			
90913	When Performed; Each Additional 15 Minutes Of One-On-	Policy Criteria. Submit for Recommended Clinical Review to			
20313	One Physician Or Other Qualified Health Care Professional		-	-	-
	Contact With The Patient (List Separately In Addition To	avoid post-service review.			
	Code For Primary Procedure)				
	(Code For Frinary Frocedure)				

	Unlisted Dialysis Procedure Inpatient Or Outpatient	Unlisted: Procedure/service not specifically defined or			
90999	, i	classified, maybe subject to contract/clinical review.	_	_	_
	Esophagus Gastroesophageal Reflux Test; With Nasal	MP Criteria: Procedure/service reviewed against Medical			
91034	Catheter Ph Electrode(S) Placement Recording Analysis And	Policy Criteria. Submit for Recommended Clinical Review to			
	Interpretation	avoid post-service review.	_	_	<u> </u>
	Esophagus Gastroesophageal Reflux Test; With Mucosal	MP Criteria: Procedure/service reviewed against Medical			
91035	Attached Telemetry Ph Electrode Placement Recording	Policy Criteria. Submit for Recommended Clinical Review to			
	Analysis And Interpretation	avoid post-service review.	_	_	-
	Esophageal Function Test Gastroesophageal Reflux Test	MP Criteria: Procedure/service reviewed against Medical			
91037	With Nasal Catheter Intraluminal Impedance Electrode(S)	Policy Criteria. Submit for Recommended Clinical Review to			
	Placement Recording Analysis And Interpretation;	avoid post-service review.	_	_	-
	Esophageal Function Test Gastroesophageal Reflux Test				
	With Nasal Catheter Intraluminal Impedance Electrode(S)	MP Criteria: Procedure/service reviewed against Medical			
91038	Placement Recording Analysis And Interpretation;	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Prolonged (Greater Than 1 Hour Up To 24 Hours)	avoid post-service review.			
	Breath Hydrogen Or Methane Test (Eg For Detection Of	EIU: Procedure/service not reimbursed by the Plan. Not			
91065	Lactase Deficiency Fructose Intolerance Bacterial	subject to pre-service review. Check EIU policy, which is			
51005	Overgrowth Or Oro-Cecal Gastrointestinal Transit)	one of our Clinical Payment and Coding Policy (CPCP).	_	-	_
	Gastrointestinal Tract Imaging Intraluminal (Eg Capsule	MP Criteria: Procedure/service reviewed against Medical			
91110		Policy Criteria. Submit for Recommended Clinical Review to			
31110	Endoscopy) Esophagus Through Ileum With Interpretation	•	_	-	-
	And Report Gastrointestinal Tract Imaging Intraluminal (Eg Capsule	avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not			
91111		· ·			
91111	Endoscopy) Esophagus With Interpretation And Report	subject to pre-service review. Check EIU policy, which is	_	-	-
	Castraintestinal Transit And Drassura Massurament	one of our Clinical Payment and Coding Policy (CPCP).			
01112	Gastrointestinal Transit And Pressure Measurement	EIU: Procedure/service not reimbursed by the Plan. Not			
91112	Stomach Through Colon Wireless Capsule With	subject to pre-service review. Check EIU policy, which is	_	-	-
	Interpretation And Report	one of our Clinical Payment and Coding Policy (CPCP).			
04442	Gastrointestinal Tract Imaging Intraluminal (Eg Capsule	EIU: Procedure/service not reimbursed by the Plan. Not			
91113	Endoscopy) Colon With Interpretation And Report	subject to pre-service review. Check EIU policy, which is	_	-	-
		one of our Clinical Payment and Coding Policy (CPCP).			
	Colon Motility (Manometric) Study Minimum 6 Hours	MP Criteria: Procedure/service reviewed against Medical			
91117	Continuous Recording (Including Provocation Tests Eg Meal	Policy Criteria. Submit for Recommended Clinical Review to			
	Intracolonic Balloon Distension Pharmacologic Agents If	avoid post-service review.	_		[
	Performed) With Interpretation And Report	FILL December 1 to 1 t			
04400	Electrogastrography Diagnostic Transcutaneous;	EIU: Procedure/service not reimbursed by the Plan. Not			
91132		subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Electrogastrography Diagnostic Transcutaneous; With	EIU: Procedure/service not reimbursed by the Plan. Not			
91133	Provocative Testing	subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
91299	Unlisted Diagnostic Gastroenterology Procedure	Unlisted: Procedure/service not specifically defined or			
		classified, maybe subject to contract/clinical review.	_	_	_
92015	Determination Of Refractive State	Non Covered: Procedure/service not covered by the Plan.			
		Not subject to pre-service review.			_
92065	Orthoptic Training; Performed By A Physician Or Other	Non Covered: Procedure/service not covered by the Plan.			
	Qualified Health Care Professional	Not subject to pre-service review.	_	-	_

	Scanning Computerized Ophthalmic Diagnostic Imaging	EIU: Procedure/service not reimbursed by the Plan. Not			
92132	Anterior Segment With Interpretation And Report	subject to pre-service review. Check EIU policy, which is	_	_	_
	Unilateral Or Bilateral	one of our Clinical Payment and Coding Policy (CPCP).			
	Corneal Hysteresis Determination By Air Impulse	EIU: Procedure/service not reimbursed by the Plan. Not			
92145	Stimulation Unilateral Or Bilateral With Interpretation And	subject to pre-service review. Check EIU policy, which is			_
	Report	one of our Clinical Payment and Coding Policy (CPCP).		Г	
	Fitting Of Spectacles Except For Aphakia; Monofocal	Non Covered: Procedure/service not covered by the Plan.			
92340		Not subject to pre-service review.	_	_	_
	Fitting Of Spectacles Except For Aphakia; Bifocal	Non Covered: Procedure/service not covered by the Plan.			
92341	Tricing of speciacies Except for Apriana, Brocar	Not subject to pre-service review.	_	_	_
	Fitting Of Spectacles Except For Aphakia; Multifocal Other	Non Covered: Procedure/service not covered by the Plan.			
92342			_	_	_
	Than Bifocal	Not subject to pre-service review.			
92354	Fitting Of Spectacle Mounted Low Vision Aid; Single Element	l i i i i i i i i i i i i i i i i i i i	_	_	_
	System	Not subject to pre-service review.			
92355	Fitting Of Spectacle Mounted Low Vision Aid; Telescopic Or	Non Covered: Procedure/service not covered by the Plan.			_
	Other Compound Lens System	Not subject to pre-service review.			
92370	Repair And Refitting Spectacles; Except For Aphakia	Non Covered: Procedure/service not covered by the Plan.			
		Not subject to pre-service review.	_	_	-
92499	Unlisted Ophthalmological Service Or Procedure	Unlisted: Procedure/service not specifically defined or			
32.33		classified, maybe subject to contract/clinical review.	-	-	-
	Nasal Function Studies (Eg Rhinomanometry)	EIU: Procedure/service not reimbursed by the Plan. Not			
92512		subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Vestibular Evoked Myogenic Potential (Vemp) Testing With	EIU: Procedure/service not reimbursed by the Plan. Not			
92517	Interpretation And Report; Cervical (Cvemp)	subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Vestibular Evoked Myogenic Potential (Vemp) Testing With	EIU: Procedure/service not reimbursed by the Plan. Not			
92518	Interpretation And Report; Ocular (Ovemp)	subject to pre-service review. Check EIU policy, which is			
		one of our Clinical Payment and Coding Policy (CPCP).	_	Г	_
	Vestibular Evoked Myogenic Potential (Vemp) Testing With	EIU: Procedure/service not reimbursed by the Plan. Not			
92519	Interpretation And Report; Cervical (Cvemp) And Ocular	subject to pre-service review. Check EIU policy, which is			
32323	(Ovemp)	one of our Clinical Payment and Coding Policy (CPCP).	_	_	-
	Sinusoidal Vertical Axis Rotational Testing	MP Criteria: Procedure/service reviewed against Medical			
92546	Sinusoradi Verticali Mis Notational Testing	Policy Criteria. Submit for Recommended Clinical Review to			
32340		avoid post-service review.	-	-	-
	Computerized Dynamic Posturography Sensory Organization				
		EIU: Procedure/service not reimbursed by the Plan. Not			
02540	Test (Cdp-Sot) 6 Conditions (le Eyes Open Eyes Closed				
92548	Visual Sway Platform Sway Eyes Closed Platform Sway	subject to pre-service review. Check EIU policy, which is	_	-	-
	Platform And Visual Sway) Including Interpretation And	one of our Clinical Payment and Coding Policy (CPCP).			
	Report;				
	Computerized Dynamic Posturography Sensory Organization				
	Test (Cdp-Sot) 6 Conditions (le Eyes Open Eyes Closed	EIU: Procedure/service not reimbursed by the Plan. Not			
92549	Visual Sway Platform Sway Eyes Closed Platform Sway	subject to pre-service review. Check EIU policy, which is			
	Platform And Visual Sway) Including Interpretation And	one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
	Report; With Motor Control Test (Mct) And Adaptation Test	one of our chimear rayment and country to dry (or or).			
	(Adt)				
	(Adt)				

	Diamontic Analysis December 2014 And Verification Of An	MD Critoria: Procedure/comics reviewed against Madical		1	
02622	Diagnostic Analysis Programming And Verification Of An	MP Criteria: Procedure/service reviewed against Medical			
92622	Auditory Osseointegrated Sound Processor Any Type; First	Policy Criteria. Submit for Recommended Clinical Review to	4/4/2024	_	Add offers 1 as 04/04/2024
	60 Minutes	avoid post-service review.	4/1/2024		Add effective 04/01/2024
	Diagnostic Analysis Programming And Verification Of An	MP Criteria: Procedure/service reviewed against Medical			
92623	Auditory Osseointegrated Sound Processor Any Type; Each	Policy Criteria. Submit for Recommended Clinical Review to			
52023	Additional 15 Minutes (List Separately In Addition To Code	avoid post-service review.		_	
	For Primary Procedure)	avoid post-service review.	4/1/2024		Add effective 04/01/2024
	Auditory Rehabilitation; Postlingual Hearing Loss	MP Criteria: Procedures/services reviewed against Medical			
92633		Policy Criteria. Submit for Recommended Clinical Review to			
92033		· ·	_	_	-
		avoid post-service review by BCBS.			
	Diagnostic Analysis With Programming Of Auditory	MP Criteria: Procedure/service reviewed against Medical			
92640	Brainstem Implant Per Hour	Policy Criteria. Submit for Recommended Clinical Review to		L	_
		avoid post-service review.			
00700	Unlisted Otorhinolaryngological Service Or Procedure	Unlisted: Procedure/service not specifically defined or			
92700		classified, maybe subject to contract/clinical review.	_	-	-
	Percutaneous Transluminal Coronary Lithotripsy (List	MP Criteria: Procedure/service reviewed against Medical			
92972	Separately In Addition To Code For Primary Procedure)	Policy Criteria. Submit for Recommended Clinical Review to			
	,,	avoid post-service review.	4/1/2024	_	Add effective 04/01/2024
	Arterial Pressure Waveform Analysis For Assessment Of				
	Central Arterial Pressures Includes Obtaining Waveform(S)				
	Digitization And Application Of Nonlinear Mathematical	EIU: Procedure/service not reimbursed by the Plan. Not			
93050	Transformations To Determine Central Arterial Pressures	subject to pre-service review. Check EIU policy, which is			
	And Augmentation Index With Interpretation And Report	one of our Clinical Payment and Coding Policy (CPCP).	-	_	_
	Upper Extremity Artery Non-Invasive	one of our chinear ayment and coding roney (er er).			
	Opper Extremity Artery Non-invasive				
	Therapy Activation Of Implanted Phrenic Nerve Stimulator	EIU: Procedure/service not reimbursed by the Plan. Not			
93150	System Including All Interrogation And Programming	subject to pre-service review. Check EIU policy, which is			
30130	System meading Air interrogation And Frogramming	one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	_	Add effective 05/15/2024
	Therapy Activation Of Implanted Phrenic Nerve Stimulator	MP Criteria: Procedure/service reviewed against Medical	3/ 23/ 202 :		
93150	System Including All Interrogation And Programming	Policy Criteria. Submit for Recommended Clinical Review to			Add effective 02/15/2024
33130	System including All Interrogation And Frogramming	avoid post-service review.	2/15/2024	5/14/2024	Retire effective 05/14/2024
	Interrogation And Programming (Minimum One Parameter)	EIU: Procedure/service not reimbursed by the Plan. Not	2, 23, 202 :	3/2:/202:	netile energine est a tip zez :
93151	Of Implanted Phrenic Nerve Stimulator System	subject to pre-service review. Check EIU policy, which is			
55151	of implanted i menic werve stimulator system	one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	-	Add effective 05/15/2024
	Interrogation And Programming (Minimum One Parameter)	MP Criteria: Procedure/service reviewed against Medical	3/13/2024		Add Circuit 03/13/2024
93151	Of Implanted Phrenic Nerve Stimulator System	Policy Criteria. Submit for Recommended Clinical Review to			Add effective 02/15/2024
93131	Of implanted Pilletiic Nerve Stillulator System	avoid post-service review.	2/15/2024	5/14/2024	Retire effective 05/14/2024
	Interrogation And Programming Of Implanted Phrenic Nerve		LJ 13/ 202 1	3/ 14/ 2024	netire effective 03/14/2024
93152		subject to pre-service review. Check EIU policy, which is			
93152	Stimulator System During Polysomnography		E /4 E /2024	-	Add offortion OF /15 /2024
	Internegation And Decreases of Insulant - 1 Division No.	one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024		Add effective 05/15/2024
02452	Interrogation And Programming Of Implanted Phrenic Nerve	-			Add offortive 03/45/2034
93152	Stimulator System During Polysomnography	Policy Criteria. Submit for Recommended Clinical Review to	2/45/2024	F /4 4 /5 5 5 .	Add effective 02/15/2024
		avoid post-service review.	2/15/2024	5/14/2024	Retire effective 05/14/2024
	Interrogation Without Programming Of Implanted Phrenic	EIU: Procedure/service not reimbursed by the Plan. Not			
93153	Nerve Stimulator System	subject to pre-service review. Check EIU policy, which is	- / / :	-	A L L 66 05 / - / 255
		one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024		Add effective 05/15/2024

93153	Interrogation Without Programming Of Implanted Phrenic Nerve Stimulator System	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to	2/45/2024		Add effective 02/15/2024
93228	External Mobile Cardiovascular Telemetry With Electrocardiographic Recording Concurrent Computerized Real Time Data Analysis And Greater Than 24 Hours Of Accessible Ecg Data Storage (Retrievable With Query) With Ecg Triggered And Patient Selected Events Transmitted To A Remote Attended Surveillance Center For Up To 30 Days; Review And Interpretation With Report By A Physician Or Other Qualified Health Care Professional	avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024 _	- -	Retire effective 05/14/2024
93229	External Mobile Cardiovascular Telemetry With Electrocardiographic Recording Concurrent Computerized Real Time Data Analysis And Greater Than 24 Hours Of Accessible Ecg Data Storage (Retrievable With Query) With Ecg Triggered And Patient Selected Events Transmitted To A Remote Attended Surveillance Center For Up To 30 Days; Technical Support For Connection And Patient Instructions For Use Attended Surveillance Analysis And Transmission Of Daily And Emergent Data Reports As Prescribed By A Physician Or Other Qualified Health Care Professional	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	-	-
93264	Remote Monitoring Of A Wireless Pulmonary Artery Pressure Sensor For Up To 30 Days Including At Least Weekly Downloads Of Pulmonary Artery Pressure Recordings Interpretation(S) Trend Analysis And Report(S) By A Physician Or Other Qualified Health Care Professional	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	-	-	-
93660	Evaluation Of Cardiovascular Function With Tilt Table Evaluation With Continuous Ecg Monitoring And Intermittent Blood Pressure Monitoring With Or Without Pharmacological Intervention	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	-	_	_
93702	Bioimpedance Spectroscopy (Bis) Extracellular Fluid Analysis For Lymphedema Assessment(S)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
93740	Temperature Gradient Studies	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
93797	Physician Or Other Qualified Health Care Professional Services For Outpatient Cardiac Rehabilitation; Without Continuous Ecg Monitoring (Per Session)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	-	-	-
93798	Physician Or Other Qualified Health Care Professional Services For Outpatient Cardiac Rehabilitation; With Continuous Ecg Monitoring (Per Session)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	-	-	_
93799	Unlisted Cardiovascular Service Or Procedure	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	-

	Halistad Navia vais a Vasa day Diagrapatia Chudu	Unlisted Dragadura (carries not specifically defined or			
93998	Unlisted Noninvasive Vascular Diagnostic Study	Unlisted: Procedure/service not specifically defined or	_	L	_
		classified, maybe subject to contract/clinical review.			
	Patient-Initiated Spirometric Recording Per 30-Day Period Of				
	Time; Includes Reinforced Education Transmission Of	EIU: Procedure/service not reimbursed by the Plan. Not			
94014	Spirometric Tracing Data Capture Analysis Of Transmitted	subject to pre-service review. Check EIU policy, which is			
	Data Periodic Recalibration And Review And Interpretation	one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
	By A Physician Or Other Qualified Health Care Professional	, , , , ,			
	Patient-Initiated Spirometric Recording Per 30-Day Period Of	EIU: Procedure/service not reimbursed by the Plan. Not			
94015	Time; Recording (Includes Hook-Up Reinforced Education	subject to pre-service review. Check EIU policy, which is			
54015	Data Transmission Data Capture Trend Analysis And	one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
	Periodic Recalibration)	one of our chilical rayment and county rolley (crer).			
	Patient-Initiated Spirometric Recording Per 30-Day Period Of	EIU: Procedure/service not reimbursed by the Plan. Not			
94016	Time; Review And Interpretation Only By A Physician Or	subject to pre-service review. Check EIU policy, which is	_	_	_
	Other Qualified Health Care Professional	one of our Clinical Payment and Coding Policy (CPCP).			
	High Altitude Simulation Test (Hast) With Interpretation	Non Covered: Procedure/service not covered by the Plan.			
94452	And Report By A Physician Or Other Qualified Health Care	Not subject to pre-service review.	_	_	-
	Professional;	not subject to pie service remem			
	High Altitude Simulation Test (Hast) With Interpretation	Non Covered: Procedure/service not covered by the Plan.			
94453	And Report By A Physician Or Other Qualified Health Care	Not subject to pre-service review.	_	_	-
	Professional; With Supplemental Oxygen Titration	· ·			
94799	Unlisted Pulmonary Service Or Procedure	Unlisted: Procedure/service not specifically defined or			
		classified, maybe subject to contract/clinical review.	_	_	-
05000	Ophthalmic Mucous Membrane Tests	EIU: Procedure/service not reimbursed by the Plan. Not			
95060		subject to pre-service review. Check EIU policy, which is	_	-	-
		one of our Clinical Payment and Coding Policy (CPCP).			
05005	Direct Nasal Mucous Membrane Test	EIU: Procedure/service not reimbursed by the Plan. Not			
95065		subject to pre-service review. Check EIU policy, which is	-	-	-
	Hallated Allege ICP steel to see a least Construction On Broad and	one of our Clinical Payment and Coding Policy (CPCP).			
95199	Unlisted Allergy/Clinical Immunologic Service Or Procedure	Unlisted: Procedure/service not specifically defined or	_	_	_
	Floatra anganhalagram (Fog) Continuous Departing (Mith	classified, maybe subject to contract/clinical review.			
	Electroencephalogram (Eeg) Continuous Recording With	MP Criteria: Procedure/service reviewed against Medical			
95700	Video When Performed Setup Patient Education And	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Takedown When Performed Administered In Person By Eeg	avoid post-service review.			
	Technologist Minimum Of 8 Channels Electroencephalogram (Eeg) Without Video Review Of Data	MP Criteria: Procedure/service reviewed against Medical			
95705	Technical Description By Eeg Technologist 2-12 Hours;	Policy Criteria. Submit for Recommended Clinical Review to			
55705	Unmonitored	avoid post-service review.	-	-	-
	Electroencephalogram (Eeg) Without Video Review Of Data				
95706	Technical Description By Eeg Technologist 2-12 Hours; With	Policy Criteria. Submit for Recommended Clinical Review to			
33700	Intermittent Monitoring And Maintenance	avoid post-service review.	-	-	-
	Electroencephalogram (Eeg) Without Video Review Of Data	<u> </u>			
	Technical Description By Eeg Technologist 2-12 Hours; With	ivip Criteria: Procedure/service reviewed against iviedical			
95707	Continuous Real-Time Monitoring And Maintenance	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Continuous hear-time Monitoring And Maintenance	avoid post-service review.			
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	Electroencephalogram (Eeg) Without Video Review Of Data				
95708	Technical Description By Eeg Technologist Each Increment	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Of 12-26 Hours; Unmonitored	avoid post-service review.			
	Electroencephalogram (Eeg) Without Video Review Of Data	MP Criteria: Procedure/service reviewed against Medical			
95709	Technical Description By Eeg Technologist Each Increment	Policy Criteria. Submit for Recommended Clinical Review to			
	Of 12-26 Hours; With Intermittent Monitoring And	avoid post-service review.	_	_	_
	Maintenance	· ·			
	Electroencephalogram (Eeg) Without Video Review Of Data	MP Criteria: Procedure/service reviewed against Medical			
95710	Technical Description By Eeg Technologist Each Increment	Policy Criteria. Submit for Recommended Clinical Review to			
337.20	Of 12-26 Hours; With Continuous Real-Time Monitoring	avoid post-service review.	_	_	_
	And Maintenance	'			
	Electroencephalogram With Video (Veeg) Review Of Data	MP Criteria: Procedure/service reviewed against Medical			
95711	Technical Description By Eeg Technologist 2-12 Hours;	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Unmonitored	avoid post-service review.			
	Electroencephalogram With Video (Veeg) Review Of Data	MP Criteria: Procedure/service reviewed against Medical			
95712	Technical Description By Eeg Technologist 2-12 Hours; With	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Intermittent Monitoring And Maintenance	avoid post-service review.			
	Electroencephalogram With Video (Veeg) Review Of Data	MP Criteria: Procedure/service reviewed against Medical			
95713	Technical Description By Eeg Technologist 2-12 Hours; With	Policy Criteria. Submit for Recommended Clinical Review to			
93/13	Continuous Real-Time Monitoring And Maintenance	avoid post-service review.	_	-	-
		avolu post-service review.			
	Electroencephalogram With Video (Veeg) Review Of Data	MP Criteria: Procedure/service reviewed against Medical			
95714	Technical Description By Eeg Technologist Each Increment	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Of 12-26 Hours; Unmonitored	avoid post-service review.			
	Electroencephalogram With Video (Veeg) Review Of Data	MP Criteria: Procedure/service reviewed against Medical			
95715	Technical Description By Eeg Technologist Each Increment	Policy Criteria. Submit for Recommended Clinical Review to			
95/15	Of 12-26 Hours; With Intermittent Monitoring And	l ·	_	-	-
	Maintenance	avoid post-service review.			
	Electroencephalogram With Video (Veeg) Review Of Data	MP Criteria: Procedure/service reviewed against Medical			
95716	Technical Description By Eeg Technologist Each Increment	Policy Criteria. Submit for Recommended Clinical Review to			
95/10	Of 12-26 Hours; With Continuous Real-Time Monitoring	· ·	_	-	-
	And Maintenance	avoid post-service review.			
	Electroencephalogram (Eeg) Continuous Recording				
	Physician Or Other Qualified Health Care Professional	MP Criteria: Procedure/service reviewed against Medical			
95717	Review Of Recorded Events Analysis Of Spike And Seizure	Policy Criteria. Submit for Recommended Clinical Review to	_		_
	Detection Interpretation And Report 2-12 Hours Of Eeg	avoid post-service review.			
	Recording; Without Video				
	Electroencephalogram (Eeg) Continuous Recording				
	Physician Or Other Qualified Health Care Professional	MP Criteria: Procedure/service reviewed against Medical			
95718	Review Of Recorded Events Analysis Of Spike And Seizure	Policy Criteria. Submit for Recommended Clinical Review to			
	Detection Interpretation And Report 2-12 Hours Of Eeg	avoid post-service review.	=	_	
	Recording; With Video (Veeg)				
	The contract of the contract o	•		•	<u> </u>

95719	Electroencephalogram (Eeg) Continuous Recording Physician Or Other Qualified Health Care Professional Review Of Recorded Events Analysis Of Spike And Seizure Detection Each Increment Of Greater Than 12 Hours Up To 26 Hours Of Eeg Recording Interpretation And Report After Each 24-Hour Period; Without Video	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	-	-	-
95720	Electroencephalogram (Eeg) Continuous Recording Physician Or Other Qualified Health Care Professional Review Of Recorded Events Analysis Of Spike And Seizure Detection Each Increment Of Greater Than 12 Hours Up To 26 Hours Of Eeg Recording Interpretation And Report After Each 24-Hour Period: With Video (Veeg)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	-	-	-
95721	Electroencephalogram (Eeg) Continuous Recording Physician Or Other Qualified Health Care Professional Review Of Recorded Events Analysis Of Spike And Seizure Detection Interpretation And Summary Report Complete Study; Greater Than 36 Hours Up To 60 Hours Of Eeg Recording Without Video	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	-	-	-
95722	Electroencephalogram (Eeg) Continuous Recording Physician Or Other Qualified Health Care Professional Review Of Recorded Events Analysis Of Spike And Seizure Detection Interpretation And Summary Report Complete Study; Greater Than 36 Hours Up To 60 Hours Of Eeg Recording With Video (Veeg)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	-	-	_
95723	Electroencephalogram (Eeg) Continuous Recording Physician Or Other Qualified Health Care Professional Review Of Recorded Events Analysis Of Spike And Seizure Detection Interpretation And Summary Report Complete Study; Greater Than 60 Hours Up To 84 Hours Of Eeg Recording Without Video	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	-	-	_
95724	Electroencephalogram (Eeg) Continuous Recording Physician Or Other Qualified Health Care Professional Review Of Recorded Events Analysis Of Spike And Seizure Detection Interpretation And Summary Report Complete Study; Greater Than 60 Hours Up To 84 Hours Of Eeg Recording With Video (Veeg)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	-	-	-
95725	Electroencephalogram (Eeg) Continuous Recording Physician Or Other Qualified Health Care Professional Review Of Recorded Events Analysis Of Spike And Seizure Detection Interpretation And Summary Report Complete Study; Greater Than 84 Hours Of Eeg Recording Without Video	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	-	-	-

95726	Electroencephalogram (Eeg) Continuous Recording Physician Or Other Qualified Health Care Professional Review Of Recorded Events Analysis Of Spike And Seizure Detection Interpretation And Summary Report Complete Study; Greater Than 84 Hours Of Eeg Recording With Video (Veeg)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	-	-	_
95803	Report (Minimum Of 72 Hours To 14 Consecutive Days Of Recording)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	-	-
95807	Sleep Study Simultaneous Recording Of Ventilation Respiratory Effort Ecg Or Heart Rate And Oxygen Saturation Attended By A Technologist	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS.	_	_	-
95808	Polysomnography; Any Age Sleep Staging With 1-3 Additional Parameters Of Sleep Attended By A Technologist	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS.	-	-	-
95810	Polysomnography; Age 6 Years Or Older Sleep Staging With 4 Or More Additional Parameters Of Sleep Attended By A Technologist	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS.	-	-	-
95811	Polysomnography; Age 6 Years Or Older Sleep Staging With 4 Or More Additional Parameters Of Sleep With Initiation Of Continuous Positive Airway Pressure Therapy Or Bilevel Ventilation Attended By A Technologist	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS.	-	-	-
95905	Motor And/Or Sensory Nerve Conduction Using Preconfigured Electrode Array(S) Amplitude And Latency/Velocity Study Each Limb Includes F-Wave Study When Performed With Interpretation And Report	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
95919	Quantitative Pupillometry With Physician Or Other Qualified Health Care Professional Interpretation And Report Unilateral Or Bilateral	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
95954	Pharmacological Or Physical Activation Requiring Physician Or Other Qualified Health Care Professional Attendance During Eeg Recording Of Activation Phase (Eg Thiopental Activation Test)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	-	-	-
95957	Digital Analysis Of Electroencephalogram (Eeg) (Eg For Epileptic Spike Analysis)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	-	-	-
95962	Functional Cortical And Subcortical Mapping By Stimulation And/Or Recording Of Electrodes On Brain Surface Or Of Depth Electrodes To Provoke Seizures Or Identify Vital Brain Structures; Each Additional Hour Of Attendance By A Physician Or Other Qualified Health Care Professional (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2024	-	Add effective 03/01/2024

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	Magnetoencephalography (Meg) Recording And Analysis;	MP Criteria: Procedure/service reviewed against Medical			
95965	For Spontaneous Brain Magnetic Activity (Eg Epileptic	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Cerebral Cortex Localization)	avoid post-service review.			
	Magnetoencephalography (Meg) Recording And Analysis;	MP Criteria: Procedure/service reviewed against Medical			
95966	For Evoked Magnetic Fields Single Modality (Eg Sensory	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Motor Language Or Visual Cortex Localization)	avoid post-service review.			
	Magnetoencephalography (Meg) Recording And Analysis;				
	For Evoked Magnetic Fields Each Additional Modality (Eg	MP Criteria: Procedure/service reviewed against Medical			
95967	Sensory Motor Language Or Visual Cortex Localization)	Policy Criteria. Submit for Recommended Clinical Review to			
	(List Separately In Addition To Code For Primary Procedure)	avoid post-service review.	_		_
	(List separately in Addition to code for Filling y Frocedure)				
	Electronic Analysis Of Implanted Neurostimulator Pulse				
	Generator System (Eg Rate Pulse Amplitude And Duration				
	Configuration Of Wave Form Battery Status Electrode	MP Criteria: Procedures/services reviewed against Medical			
95980	Selectability Output Modulation Cycling Impedance And	Policy Criteria. Submit for Recommended Clinical Review to			
	Patient Measurements) Gastric Neurostimulator Pulse	avoid post-service review by BCBS.	_	-	-
	Generator/Transmitter; Intraoperative With Programming	avoid post service review by bebs.			
	Generator/ transmitter; intraoperative with Programming				
	Electronic Analysis Of Implanted Neurostimulator Pulse				
	Generator System (Eg Rate Pulse Amplitude And Duration				
	Configuration Of Wave Form Battery Status Electrode	MP Criteria: Procedure/service reviewed against Medical			
95981	Selectability Output Modulation Cycling Impedance And	Policy Criteria. Submit for Recommended Clinical Review to			
	Patient Measurements) Gastric Neurostimulator Pulse	avoid post-service review.	_	_	-
	Generator/Transmitter; Subsequent Without	avoid post service review.			
	Reprogramming				
	Electronic Analysis Of Implanted Neurostimulator Pulse				
	Generator System (Eg Rate Pulse Amplitude And Duration				
	Configuration Of Wave Form Battery Status Electrode	MP Criteria: Procedure/service reviewed against Medical			
95982.00		Policy Criteria. Submit for Recommended Clinical Review to			
33302.00	Selectability Output Modulation Cycling Impedance And	avoid post-service review.	_	-	_
	Patient Measurements) Gastric Neurostimulator Pulse	avolu post-service review.			
	Generator/Transmitter; Subsequent With Reprogramming				
	Unlisted Neurological Or Neuromuscular Diagnostic	Unlisted: Procedure/service not specifically defined or			
95999	Procedure	classified, maybe subject to contract/clinical review.	_	_	_
	Comprehensive Computer-Based Motion Analysis By Video-	MP Criteria: Procedure/service reviewed against Medical			
96000	Taping And 3D Kinematics;	Policy Criteria. Submit for Recommended Clinical Review to			
30000	raping And 3D Kinematics,	avoid post-service review.	-	-	_
	Comprehensive Computer-Based Motion Analysis By Video-	MP Criteria: Procedure/service reviewed against Medical			
96001	Taping And 3D Kinematics; With Dynamic Plantar Pressure	Policy Criteria. Submit for Recommended Clinical Review to			
30001	Measurements During Walking	avoid post-service review.	_	-	_
	Dynamic Surface Electromyography During Walking Or	MP Criteria: Procedure/service reviewed against Medical			
96002	Other Functional Activities 1-12 Muscles	Policy Criteria. Submit for Recommended Clinical Review to			
30002	Other Functional Activities 1-12 Muscles	i i	_	-	-
	Dynamia Fina Wira Flactromyagraphy Dyning Walling Co	avoid post-service review. MP Criteria: Procedure/service reviewed against Medical			
05000	Dynamic Fine Wire Electromyography During Walking Or	·			
96003	Other Functional Activities 1 Muscle	Policy Criteria. Submit for Recommended Clinical Review to	_	-	_
		avoid post-service review.			

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	Review And Interpretation By Physician Or Other Qualified				
	Health Care Professional Of Comprehensive Computer-				
	Based Motion Analysis Dynamic Plantar Pressure	MP Criteria: Procedure/service reviewed against Medical			
96004	Measurements Dynamic Surface Electromyography During	Policy Criteria. Submit for Recommended Clinical Review to	-	-	_
	Walking Or Other Functional Activities And Dynamic Fine	avoid post-service review.			
	Wire Electromyography With Written Report				
96379	Unlisted Therapeutic Prophylactic Or Diagnostic	Unlisted: Procedure/service not specifically defined or			
90379	Intravenous Or Intra-Arterial Injection Or Infusion	classified, maybe subject to contract/clinical review.	_	-	-
	Intraoperative Hyperthermic Intraperitoneal				
	Chemotherapy (Hipec) Procedure Including Separate	MP Criteria: Procedure/service reviewed against			
96547	Incision(S) And Closure When Performed; First 60	Medical Policy Criteria. Submit for Recommended			
	Minutes (List Separately In Addition To Code For	Clinical Review to avoid post-service review.			
	Primary Procedure)	'	4/1/2024		Add effective 04/01/2024
	Intraoperative Hyperthermic Intraperitoneal		-, -,		
	Chemotherapy (Hipec) Procedure Including Separate	MP Criteria: Procedure/service reviewed against			
96548	Incision(S) And Closure When Performed; Each	Medical Policy Criteria. Submit for Recommended			
90346	, ,			_	
	Additional 30 Minutes (List Separately In Addition To	Clinical Review to avoid post-service review.	4 /4 /2024		Add offeration 04/01/2024
	Code For Primary Procedure)		4/1/2024		Add effective 04/01/2024
96549	Unlisted Chemotherapy Procedure	Unlisted: Procedure/service not specifically defined or			
	Dhatachanathanan Daoisleac Aid Illian ialat A (Duna)	classified, maybe subject to contract/clinical review. MP Criteria: Procedure/service reviewed against Medical			
96912	Photochemotherapy; Psoralens And Ultraviolet A (Puva)				
90912		Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	-	-
	Photochemotherapy (Goeckerman And/Or Puva) For Severe	avoid post-service review.			
	Photoresponsive Dermatoses Requiring At Least 4-8 Hours	MP Criteria: Procedure/service reviewed against Medical			
96913	Of Care Under Direct Supervision Of The Physician (Includes	Policy Criteria. Submit for Recommended Clinical Review to			
	Application Of Medication And Dressings)	avoid post-service review.	_	_	_
	Application of Medication / the Bressings/				
	Excimer Laser Treatment For Psoriasis; Over 500 Sq Cm	MP Criteria: Procedure/service reviewed against Medical			
96922		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Reflectance Confocal Microscopy (Rcm) For Cellular And Sub-	MP Criteria: Procedure/service reviewed against Medical			
96931	Cellular Imaging Of Skin; Image Acquisition And	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Interpretation And Report First Lesion	avoid post-service review.			
	Reflectance Confocal Microscopy (Rcm) For Cellular And Sub-				
96932	Cellular Imaging Of Skin; Image Acquisition Only First Lesion	l ·	-	_	-
	2 (1) 2 (1) 12 (2) 5 (2) 1 1 1 1 1 2 1	avoid post-service review.			
0.000	Reflectance Confocal Microscopy (Rcm) For Cellular And Sub-				
96933	Cellular Imaging Of Skin; Interpretation And Report Only	Policy Criteria. Submit for Recommended Clinical Review to	-	-	-
	First Lesion Reflectance Confocal Microscopy (Rcm) For Cellular And Sub-	avoid post-service review.			
		MP Criteria: Procedure/service reviewed against Medical			
96934	Cellular Imaging Of Skin; Image Acquisition And Interpretation And Report Each Additional Lesion (List	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	·	avoid post-service review.			
	Separately In Addition To Code For Primary Procedure)	l .			

	Reflectance Confocal Microscopy (Rcm) For Cellular And Sub-	MP Criteria: Procedure/service reviewed against Medical			
96935	Cellular Imaging Of Skin; Image Acquisition Only Each	Policy Criteria. Submit for Recommended Clinical Review to			
30333	Additional Lesion (List Separately In Addition To Code For	avoid post-service review.	_	_	_
	Primary Procedure)	avoid post service review.			
	Reflectance Confocal Microscopy (Rcm) For Cellular And Sub-	MP Criteria: Procedure/service reviewed against Medical			
96936	Cellular Imaging Of Skin; Interpretation And Report Only	Policy Criteria. Submit for Recommended Clinical Review to			
30330	Each Additional Lesion (List Separately In Addition To Code	avoid post-service review.	_	-	_
	For Primary Procedure)	·			
96999	Unlisted Special Dermatological Service Or Procedure	Unlisted: Procedure/service not specifically defined or			
30333		classified, maybe subject to contract/clinical review.	-	-	-
	Application Of A Modality To 1 Or More Areas; Low-Level	MP Criteria: Procedure/service reviewed against Medical			
97037	Laser Therapy (Ie Nonthermal And Non-Ablative) For Post-	Policy Criteria. Submit for Recommended Clinical Review to		_	
	Operative Pain Reduction	avoid post-service review.	2/15/2024		Add effective 02/15/2024
	Unlisted Modality (Specify Type And Time If Constant	Unlisted: Procedure/service not specifically defined or			
97039	Attendance)	classified, maybe subject to contract/clinical review. Prior			
		Authorization may be required per contract agreement.	_	_	_
	Unlisted Therapeutic Procedure (Specify)	Unlisted: Procedure/service not specifically defined or			
97139		classified, maybe subject to contract/clinical review. Prior			
		Authorization may be required per contract agreement.	_	_	_
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	Athletic Training Evaluation Low Complexity Requiring				
	These Components: A History And Physical Activity Profile				
	With No Comorbidities That Affect Physical Activity; An				
	Examination Of Affected Body Area And Other Symptomatic				
	Or Related Systems Addressing 1-2 Elements From Any Of	New Covered Dracedows/service and severed by the Disc			
97169	The Following: Body Structures Physical Activity And/Or	Non Covered: Procedure/service not covered by the Plan.	_		_
	Participation Deficiencies; And Clinical Decision Making Of	Not subject to pre-service review.			
	Low Complexity Using Standardized Patient Assessment				
	Instrument And/Or Measurable Assessment Of Functional				
	Outcome. Typically 15 Minutes Are Spent Face-To-Face				
	With The Patient And/Or Family.				
	Athletic Training Evaluation Moderate Complexity				
	Requiring These Components: A Medical History And				
	Physical Activity Profile With 1-2 Comorbidities That Affect				
	Physical Activity; An Examination Of Affected Body Area And				
	Other Symptomatic Or Related Systems Addressing A Total	Non Covered: Procedure/service not covered by the Plan.			
97170	Of 3 Or More Elements From Any Of The Following: Body	Not subject to pre-service review.	_	_	_
	Structures Physical Activity And/Or Participation	The subject to pie service review.			
	Deficiencies; And Clinical Decision Making Of Moderate				
	Complexity Using Standardized Patient Assessment				
	Instrument And/Or Measurable Assessment Of Functional				
	Outcome. Typically 30 Minutes Are Spent Face-To-Face				
	With The Patient And/Or Family				

97171	Athletic Training Evaluation High Complexity Requiring These Components: A Medical History And Physical Activity Profile With 3 Or More Comorbidities That Affect Physical Activity; A Comprehensive Examination Of Body Systems Using Standardized Tests And Measures Addressing A Total Of 4 Or More Elements From Any Of The Following: Body Structures Physical Activity And/Or Participation Deficiencies; Clinical Presentation With Unstable And Unpredictable Characteristics; And Clinical Decision Making Of High Complexity Using Standardized Patient Assessment Instrument And/Or Measurable Assessment Of Functional Outcome. Typically 45 Minutes Are Spent Face-To-Face With The Patient And/Or Family. Re-Evaluation Of Athletic Training Established Plan Of Care	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
97172	Re-Evaluation Of Athletic Training Established Plan Of Care Requiring These Components: An Assessment Of Patient'S Current Functional Status When There Is A Documented Change; And A Revised Plan Of Care Using A Standardized Patient Assessment Instrument And/Or Measurable Assessment Of Functional Outcome With An Update In Management Options Goals And Interventions. Typically 20 Minutes Are Spent Face-To-Face With The Patient And/Or Family.	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
97533	Sensory Integrative Techniques To Enhance Sensory Processing And Promote Adaptive Responses To Environmental Demands Direct (One-On-One) Patient Contact Each 15 Minutes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	-		-
97537	Community/Work Reintegration Training (Eg Shopping Transportation Money Management Avocational Activities And/Or Work Environment/Modification Analysis Work Task Analysis Use Of Assistive Technology Device/Adaptive Equipment) Direct One-On-One Contact Each 15 Minutes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	-	-	-
97610	Low Frequency Non-Contact Non-Thermal Ultrasound Including Topical Application(S) When Performed Wound Assessment And Instruction(S) For Ongoing Care Per Day	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
97799	Unlisted Physical Medicine/Rehabilitation Service Or Procedure	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-		-
98978	Remote therapeutic monitoring (eg, therapy adherence, therapy response); device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor cognitive behavioral therapy, each 30 days	MP Criteria: Procedure/service reviewed against Medical	-		Retire effective 2/29/2024

	Postoperative Follow-Up Visit Normally Included In The				
	Surgical Package To Indicate That An Evaluation And				
99024	Management Service Was Performed During A	Non Covered: Procedure/service not covered by the Plan.			
3302 .	Postoperative Period For A Reason(S) Related To The	Not subject to pre-service review.	_	_	_
	Original Procedure				
	Hospital Mandated On Call Service; In-Hospital Each Hour	Non Covered: Procedure/service not covered by the Plan.			
99026		Not subject to pre-service review.	-	_	_
00007	Hospital Mandated On Call Service; Out-Of-Hospital Each	Non Covered: Procedure/service not covered by the Plan.			
99027	Hour	Not subject to pre-service review.	-	-	_
	Services Provided In The Office At Times Other Than				
99050	Regularly Scheduled Office Hours Or Days When The Office	Unlisted: Procedure/service not specifically defined or			
99050	Is Normally Closed (Eg Holidays Saturday Or Sunday) In	classified, maybe subject to contract/clinical review.	-	-	-
	Addition To Basic Service				
	Service(S) Typically Provided In The Office Provided Out Of	Unlisted: Procedure/service not specifically defined or			
99056	The Office At Request Of Patient In Addition To Basic	classified, maybe subject to contract/clinical review.	_	_	_
	Service	classifica, maybe subject to contract, cliffical review.			
	Service(S) Provided On An Emergency Basis In The Office	Unlisted: Procedure/service not specifically defined or			
99058	Which Disrupts Other Scheduled Office Services In Addition	classified, maybe subject to contract/clinical review.	_	_	_
	To Basic Service	classification and the control of th			
	Supplies And Materials (Except Spectacles) Provided By The				
	Physician Or Other Qualified Health Care Professional Over	Unlisted: Procedure/service not specifically defined or			
99070	And Above Those Usually Included With The Office Visit Or	classified, maybe subject to contract/clinical review.	_	_	_
	Other Services Rendered (List Drugs Trays Supplies Or	, , , , , , , , , , , , , , , , , , , ,			
	Materials Provided)				
	Educational Supplies Such As Books Tapes And Pamphlets	Non Covered: Procedure/service not covered by the Plan.			
99071	For The Patient'S Education At Cost To Physician Or Other	Not subject to pre-service review.	-	_	_
	Qualified Health Care Professional	Non Covered: Procedure/service not covered by the Plan.			
	Medical Testimony	•			
00075		Not subject to pre-service review.			
99075		Unlisted or Undefined: Procedures/services not specifically	-	-	_
		defined or classified, maybe subject to contract/clinical			
	Physician Or Other Qualified Health Care Professional	review.			
	Qualified By Education Training Licensure/Regulation				
99078	(When Applicable) Educational Services Rendered To	Unlisted: Procedure/service not specifically defined or			
33070	Patients In A Group Setting (Eg Prenatal Obesity Or	classified, maybe subject to contract/clinical review.	-	-	_
	Diabetic Instructions)				
	Special Reports Such As Insurance Forms More Than The	Non Covered: Procedure/service not covered by the Plan.			
	Information Conveyed In The Usual Medical	Not subject to pre-service review.			
99080	Communications Or Standard Reporting Form	Unlisted or Undefined: Procedures/services not specifically			
	de la communicación de la	defined or classified, maybe subject to contract/clinical	_	_	_
		review.			
00000	Unusual Travel (Eg Transportation And Escort Of Patient)	Unlisted: Procedure/service not specifically defined or			
99082		classified, maybe subject to contract/clinical review.	-	-	-
00100	Unlisted Special Service Procedure Or Report	Unlisted: Procedure/service not specifically defined or			
99199		classified, maybe subject to contract/clinical review.	-	-	_
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	Standby Service Requiring Prolonged Attendance Each 30				
99360	Minutes (Eg Operative Standby Standby For Frozen Section	Non Covered: Procedure/service not covered by the Plan.			
	For Cesarean/High Risk Delivery For Monitoring Eeg)	Not subject to pre-service review.	_	_	_
	Unlisted December Madicine Comics	Unlisted Procedure (consider not specifically defined or			
99429	Unlisted Preventive Medicine Service	Unlisted: Procedure/service not specifically defined or	_	_	_
	Interprofessional Telephone/Internet/Electronic Health	classified, maybe subject to contract/clinical review.			
	Record Assessment And Management Service Provided By A				
99446	Consultative Physician Or Other Qualified Health Care	Non Covered: Procedure/service not covered by the Plan.			
99440	Professional Including A Verbal And Written Report To The	Not subject to pre-service review.	_	-	_
	Patient'S Treating/Requesting Physician Or Other Qualified				
	Health Care Professional; 5-10 Minutes Of Medical				
	Consultative Discussion And Review Interprofessional Telephone/Internet/Electronic Health				
	Record Assessment And Management Service Provided By A				
	Consultative Physician Or Other Qualified Health Care				
99447	Professional Including A Verbal And Written Report To The	Not subject to pre-service review.			
33117	Patient'S Treating/Requesting Physician Or Other Qualified		-	_	-
	Health Care Professional; 11-20 Minutes Of Medical				
	Consultative Discussion And Review				
	Interprofessional Telephone/Internet/Electronic Health				
	Record Assessment And Management Service Provided By A	Non Covered: Procedure/service not covered by the Plan.			
	Consultative Physician Or Other Qualified Health Care				
99448	Professional Including A Verbal And Written Report To The				
	Patient'S Treating/Requesting Physician Or Other Qualified	Not subject to pre-service review.			
	Health Care Professional; 21-30 Minutes Of Medical				
	Consultative Discussion And Review				
	Interprofessional Telephone/Internet/Electronic Health				
	Record Assessment And Management Service Provided By A				
	Consultative Physician Or Other Qualified Health Care	Non Covered: Procedure/service not covered by the Plan.			
99449	Professional Including A Verbal And Written Report To The	Not subject to pre-service review.	_	_	_
	Patient'S Treating/Requesting Physician Or Other Qualified	Not subject to pre-service review.			
	Health Care Professional; 31 Minutes Or More Of Medical				
	Consultative Discussion And Review				
	Basic Life And/Or Disability Examination That Includes:				
	Measurement Of Height Weight And Blood Pressure;				
	Completion Of A Medical History Following A Life Insurance	Non Covered: Procedure/service not covered by the Plan.			
99450	Pro Forma; Collection Of Blood Sample And/Or Urinalysis	Not subject to pre-service review.	-	_	_
	Complying With Chain Of Custody Protocols; And	, , , , , , , , , , , , , , , , , , ,			
	Completion Of Necessary Documentation/Certificates.				

99451	Interprofessional Telephone/Internet/Electronic Health Record Assessment And Management Service Provided By A Consultative Physician Or Other Qualified Health Care Professional Including A Written Report To The Patient'S Treating/Requesting Physician Or Other Qualified Health Care Professional 5 Minutes Or More Of Medical Consultative Time	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-
99452	Interprofessional Telephone/Internet/Electronic Health Record Referral Service(S) Provided By A Treating/Requesting Physician Or Other Qualified Health Care Professional 30 Minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	_	-
99453	Remote Monitoring Of Physiologic Parameter(S) (Eg Weight Blood Pressure Pulse Oximetry Respiratory Flow Rate) Initial; Set-Up And Patient Education On Use Of Equipment	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-
99454	Remote Monitoring Of Physiologic Parameter(S) (Eg Weight Blood Pressure Pulse Oximetry Respiratory Flow Rate) Initial; Device(S) Supply With Daily Recording(S) Or Programmed Alert(S) Transmission Each 30 Days	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-
99455	Work Related Or Medical Disability Examination By The Treating Physician That Includes: Completion Of A Medical History Commensurate With The Patient'S Condition; Performance Of An Examination Commensurate With The Patient'S Condition; Formulation Of A Diagnosis Assessment Of Capabilities And Stability And Calculation Of Impairment; Development Of Future Medical Treatment Plan; And Completion Of Necessary Documentation/Certificates And Report	INOL SUDJECT TO DIE-SELVICE LEVIEW.	-	_	_
99456	Work Related Or Medical Disability Examination By Other Than The Treating Physician That Includes: Completion Of A Medical History Commensurate With The Patient'S Condition; Performance Of An Examination Commensurate With The Patient'S Condition; Formulation Of A Diagnosis Assessment Of Capabilities And Stability And Calculation Of Impairment; Development Of Future Medical Treatment Plan; And Completion Of Necessary	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	-	_
99457	Remote Physiologic Monitoring Treatment Management Services Clinical Staff/Physician/Other Qualified Health Care Professional Time In A Calendar Month Requiring Interactive Communication With The Patient/Caregiver During The Month; First 20 Minutes	INOU (Overed, Procedifie/Service not covered by the Figu	-	-	-

99491	Chronic Care Management Services With The Following Required Elements: Multiple (Two Or More) Chronic Conditions Expected To Last At Least 12 Months Or Until The Death Of The Patient Chronic Conditions That Place The Patient At Significant Risk Of Death Acute Exacerbation/Decompensation Or Functional Decline Comprehensive Care Plan Established Implemented Revised Or Monitored; First 30 Minutes Provided Personally By A Physician Or Other Qualified Health Care Professional	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-
99499	Unlisted Evaluation And Management Service	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
99600	Unlisted Home Visit Service Or Procedure	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	-	-
0001U	Red Blood Cell Antigen Typing Dna Human Erythrocyte Antigen Gene Analysis Of 35 Antigens From 11 Blood Groups Utilizing Whole Blood Common Rbc Alleles Reported	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
0004M	Scoliosis Dna Analysis Of 53 Single Nucleotide Polymorphisms (Snps) Using Saliva Prognostic Algorithm Reported As A Risk Score	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
0005U	Oncology (Prostate) Gene Expression Profile By Real-Time Rt- Pcr Of 3 Genes (Erg Pca3 And Spdef) Urine Algorithm Reported As Risk Score	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
0006M	Oncology (Hepatic) Mrna Expression Levels Of 161 Genes Utilizing Fresh Hepatocellular Carcinoma Tumor Tissue With Alpha-Fetoprotein Level Algorithm Reported As A Risk Classifier	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
0007М	Oncology (Gastrointestinal Neuroendocrine Tumors) Real- Time Pcr Expression Analysis Of 51 Genes Utilizing Whole Peripheral Blood Algorithm Reported As A Nomogram Of Tumor Disease Index	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
0011M	Oncology Prostate Cancer Mrna Expression Assay Of 12 Genes (10 Content And 2 Housekeeping) Rt-Pcr Test Utilizing Blood Plasma And Urine Algorithms To Predict High Grade Prostate Cancer Risk	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_	-
0012M	Oncology (Urothelial) Mrna Gene Expression Profiling By Real-Time Quantitative Pcr Of Five Genes (Mdk Hoxa13 Cdc2 [Cdk1] Igfbp5 And Cxcr2) Utilizing Urine Algorithm Reported As A Risk Score For Having Urothelial Carcinoma	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_	-
0013M	Oncology (Urothelial) Mrna Gene Expression Profiling By Real-Time Quantitative Pcr Of Five Genes (Mdk Hoxa13 Cdc2 [Cdk1] Igfbp5 And Cxcr2) Utilizing Urine Algorithm Reported As A Risk Score For Having Recurrent Urothelial Carcinoma	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-

		T	1	1	1
	Oncology (Bladder) Mrna Microarray Gene Expression				
	Profiling Of 219 Genes Utilizing Formalin-Fixed Paraffin-	MP Criteria: Procedures/services reviewed against Medical			
0016M	Embedded Tissue Algorithm Reported As Molecular	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Subtype (Luminal Luminal Infiltrated Basal Basal Claudin-	avoid post-service review by Carelon.			
	Low Neuroendocrine-Like)				
	Oncology (Hematolymphoid Neoplasia) Rna Bcr/Abl1 Major				
	And Minor Breakpoint Fusion Transcripts Quantitative Pcr	MP Criteria: Procedures/services reviewed against Medical			
0016U	Amplification Blood Or Bone Marrow Report Of Fusion Not	Policy Criteria. Submit for Recommended Clinical Review to			_
	Detected Or Detected With Quantitation	avoid post-service review by Carelon.			
	Oncology (Diffuse Large B-Cell Lymphoma [Dlbcl]) Mrna	NAD Criteria December 2012			
004714	Gene Expression Profiling By Fluorescent Probe	MP Criteria: Procedures/services reviewed against Medical			
0017M	Hybridization Of 20 Genes Formalin-Fixed Paraffin-	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Embedded Tissue Algorithm Reported As Cell Of Origin	avoid post-service review by Carelon.			
	Oncology (Hematolymphoid Neoplasia) Jak2 Mutation Dna	NAD Critoria, Dragoduros (comigos regioned accident NAC disc)			
0017U	Pcr Amplification Of Exons 12-14 And Sequence Analysis	MP Criteria: Procedures/services reviewed against Medical			
00170	Blood Or Bone Marrow Report Of Jak2 Mutation Not	Policy Criteria. Submit for Recommended Clinical Review to	_	-	_
	Detected Or Detected	avoid post-service review by Carelon.			
	Oncology (Thyroid) Microrna Profiling By Rt-Pcr Of 10	MP Criteria: Procedures/services reviewed against Medical			
001011	Microrna Sequences Utilizing Fine Needle Aspirate	,			
0018U	Algorithm Reported As A Positive Or Negative Result For	Policy Criteria. Submit for Recommended Clinical Review to	-	-	_
	Moderate To High Risk Of Malignancy	avoid post-service review by Carelon.			
	Oncology Rna Gene Expression By Whole Transcriptome	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to			
0019U	Sequencing Formalin-Fixed Paraffin Embedded Tissue Or				
00190	Fresh Frozen Tissue Predictive Algorithm Reported As	avoid post-service review by Carelon.	_	-	_
	Potential Targets For Therapeutic Agents	avoid post-service review by Careion.			
	Targeted Genomic Sequence Analysis Panel Nonsmall Cell				
	Lung Neoplasia Dna And Rna Analysis 23 Genes	MP Criteria: Procedures/services reviewed against Medical			
0022U	Interrogation For Sequence Variants And Rearrangements	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Reported As Presence/-Or Absence Of Variants And	avoid post-service review by Carelon.			
	Associated Therapy(les) To Consider				
	Oncology (Acute Myelogenous Leukemia) Dna Genotyping				
	Of Internal Tandem Duplication P.D835 P.I836 Using	MP Criteria: Procedures/services reviewed against Medical			
0023U	Mononuclear Cells Reported As Detection Or Non-Detection	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Of Flt3 Mutation And Indication For Or Against The Use Of	avoid post-service review by Carelon.			
	Midostaurin				
	Oncology (Thyroid) Dna And Mrna Of 112 Genes Next-				
	Generation Sequencing Fine Needle Aspirate Of Thyroid	MP Criteria: Procedures/services reviewed against Medical			
0026U	Nodule Algorithmic Analysis Reported As A Categorical	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Result (Positive High Probability Of Malignancy Or Negative	avoid post-service review by Carelon.			
	Low Probability Of Malignancy)				
	Jak2 (Janus Kinase 2) (Eg Myeloproliferative Disorder) Gene	MP Criteria: Procedures/services reviewed against Medical			
0027U	Analysis Targeted Sequence Analysis Exons 12-15	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by Carelon.			

	Drug Metabolism (Adverse Drug Reactions And Drug	MP Criteria: Procedures/services reviewed against Medical			
0029U	Response) Targeted Sequence Analysis (le Cyp1A2	Policy Criteria. Submit for Recommended Clinical Review to	_		
	Cyp2C19 Cyp2C9 Cyp2D6 Cyp3A4 Cyp3A5 Cyp4F2 Slco1B1 Vkorc1 And Rs12777823)	avoid post-service review by Carelon.			
	Drug Metabolism (Warfarin Drug Response) Targeted	MP Criteria: Procedures/services reviewed against Medical			
0030U	Sequence Analysis (Ie Cyp2C9 Cyp4F2 Vkorc1	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Rs12777823)	avoid post-service review by Carelon.			
	Cyp1A2 (Cytochrome P450 Family 1 Subfamily A Member	MP Criteria: Procedures/services reviewed against Medical			
0031U	2)(Eg Drug Metabolism) Gene Analysis Common Variants	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	(le *1F *1K *6 *7)	avoid post-service review by Carelon.			
	Comt (Catechol-O-Methyltransferase)(Drug Metabolism)	MP Criteria: Procedures/services reviewed against Medical			
0032U	Gene Analysis C.472G>A (Rs4680) Variant	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by Carelon.			
	Htr2A (5-Hydroxytryptamine Receptor 2A) Htr2C (5-				
	Hydroxytryptamine Receptor 2C) (Eg Citalopram	MP Criteria: Procedures/services reviewed against Medical			
0033U	Metabolism) Gene Analysis Common Variants (le Htr2A	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Rs7997012 [C.614-2211T>C] Htr2C Rs3813929 [C759C>T]	avoid post-service review by Carelon.			
	And Rs1414334 [C.551-3008C>G])				
	Tpmt (Thiopurine S-Methyltransferase) Nudt15 (Nudix	MP Criteria: Procedures/services reviewed against Medical			
0034U	Hydroxylase 15)(Eg Thiopurine Metabolism) Gene Analysis	Policy Criteria. Submit for Recommended Clinical Review to			
	Common Variants (le Tpmt *2 *3A *3B *3C *4 *5 *6 *8	avoid post-service review by Carelon.	_		_
	*12; Nudt15 *3 *4 *5)	AAD Citation December 2012 and accident Marking			
003611	Exome (le Somatic Mutations) Paired Formalin-Fixed	MP Criteria: Procedures/services reviewed against Medical			
0036U	Paraffin-Embedded Tumor Tissue And Normal Specimen	Policy Criteria. Submit for Recommended Clinical Review to	_	-	_
	Sequence Analyses	avoid post-service review by Carelon.			
	Targeted Genomic Sequence Analysis Solid Organ Neoplasm	MP Criteria: Procedures/services reviewed against Medical			
0037U	Dna Analysis Of 324 Genes Interrogation For Sequence Variants Gene Copy Number Amplifications Gene	Policy Criteria. Submit for Recommended Clinical Review to			
00370		avoid post-service review by Carelon.	_	_	_
	Rearrangements Microsatellite Instability And Tumor Mutational Burden	avoid post-service review by careion.			
	Bcr/Abl1 (T(9;22)) (Eg Chronic Myelogenous Leukemia)	MP Criteria: Procedures/services reviewed against Medical			
0040U	Translocation Analysis Major Breakpoint Quantitative	Policy Criteria. Submit for Recommended Clinical Review to			
	Transferdion / marysis (wajor Breakpoint Quantitative	avoid post-service review by Carelon.	_	_	_
	Cerebral Perfusion Analysis Using Computed Tomography				
	With Contrast Administration Including Post-Processing Of	MP Criteria: Procedures/services reviewed against Medical			
0042T	Parametric Maps With Determination Of Cerebral Blood	Policy Criteria. Submit for Recommended Clinical Review to	_		
	Flow Cerebral Blood Volume And Mean Transit Time	avoid post-service review by BCBS.			
	Oncology (Breast Ductal Carcinoma In Situ) Mrna Gene				
	Expression Profiling By Real-Time Rt-Pcr Of 12 Genes (7	MP Criteria: Procedures/services reviewed against Medical			
0045U	Content And 5 Housekeeping) Utilizing Formalin-Fixed	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Paraffin-Embedded Tissue Algorithm Reported As	avoid post-service review by Carelon.			
	Recurrence Score				
	Flt3 (Fms-Related Tyrosine Kinase 3) (Eg Acute Myeloid	MP Criteria: Procedures/services reviewed against Medical			
0046U	Leukemia) Internal Tandem Duplication (Itd) Variants	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Quantitative	avoid post-service review by Carelon.			

0047U	Oncology (Prostate) Mrna Gene Expression Profiling By Real Time Rt-Pcr Of 17 Genes (12 Content And 5 Housekeeping) Utilizing Formalin-Fixed Paraffin-Embedded Tissue Algorithm Reported As A Risk Score	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
0048U	Oncology (Solid Organ Neoplasia) Dna Targeted Sequencing Of Protein-Coding Exons Of 468 Cancer-Associated Genes Including Interrogation For Somatic Mutations And Microsatellite Instability Matched With Normal Specimens Utilizing Formalin-Fixed Paraffin-Embedded Tumor Tissue Report Of Clinically Significant Mutation(S)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	_
0049U	Npm1 (Nucleophosmin) (Eg Acute Myeloid Leukemia) Gene Analysis Quantitative	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
0050U	Targeted Genomic Sequence Analysis Panel Acute Myelogenous Leukemia Dna Analysis 194 Genes Interrogation For Sequence Variants Copy Number Variants Or Rearrangements	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
0052U	Lipoprotein Blood High Resolution Fractionation And Quantitation Of Lipoproteins Including All Five Major Lipoprotein Classes And Subclasses Of Hdl Ldl And Vldl By Vertical Auto Profile Ultracentrifugation	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
0054T	Computer-Assisted Musculoskeletal Surgical Navigational Orthopedic Procedure With Image-Guidance Based On Fluoroscopic Images (List Separately In Addition To Code For Primary Procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
0055T	Computer-Assisted Musculoskeletal Surgical Navigational Orthopedic Procedure With Image-Guidance Based On Ct/Mri Images (List Separately In Addition To Code For Primary Procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
0055U	Cardiology (Heart Transplant) Cell-Free Dna Pcr Assay Of 96 Dna Target Sequences (94 Single Nucleotide Polymorphism Targets And Two Control Targets) Plasma	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	_
0060U	Twin Zygosity Genomic Targeted Sequence Analysis Of Chromosome 2 Using Circulating Cell-Free Fetal Dna In Maternal Blood	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	-	-
0062U	Autoimmune (Systemic Lupus Erythematosus) Igg And Igm Analysis Of 80 Biomarkers Utilizing Serum Algorithm Reported With A Risk Score	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
0063U	Neurology (Autism) 32 Amines By Lc-Ms/Ms Using Plasma Algorithm Reported As Metabolic Signature Associated With Autism Spectrum Disorder	one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
0069U	Oncology (Colorectal) Microrna Rt-Pcr Expression Profiling Of Mir-31-3P Formalin-Fixed Paraffin-Embedded Tissue Algorithm Reported As An Expression Score	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-

	Cyp2D6 (Cytochrome P450 Family 2 Subfamily D				
	Polypeptide 6) (Eg. Drug Metabolism) Gene Analysis	MP Criteria: Procedures/services reviewed against Medical			
0070U	Common And Select Rare Variants (le *2 *3 *4 *4N *5 *6	•			
00700			_	-	_
	*7 *8 *9 *10 *11 *12 *13 *14A *14B *15 *17 *29	avoid post-service review by Carelon.			
	*35 *36 *41 *57 *61 *63 *68 *83 *Xn) Focused Ultrasound Ablation Of Uterine Leiomyomata	MP Criteria: Procedure/service reviewed against Medical			
0071T	•	Policy Criteria. Submit for Recommended Clinical Review to			
00711	Including Mr Guidance; Total Leiomyomata Volume Less	· ·	_	-	_
	Than 200 Cc Of Tissue Cyp2D6 (Cytochrome P450 Family 2 Subfamily D	avoid post-service review.			
		MP Criteria: Procedures/services reviewed against Medical			
0071U	Polypeptide 6) (Eg Drug Metabolism) Gene Analysis Full	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Gene Sequence (List Separately In Addition To Code For	avoid post-service review by Carelon.			
	Primary Procedure) Focused Ultrasound Ablation Of Uterine Leiomyomata	MP Criteria: Procedure/service reviewed against Medical			
00727	·	,			
0072T	Including Mr Guidance; Total Leiomyomata Volume Greater	Policy Criteria. Submit for Recommended Clinical Review to	_	-	
	Or Equal To 200 Cc Of Tissue	avoid post-service review.			
	Cyp2D6 (Cytochrome P450 Family 2 Subfamily D	NAD Critaria. Duana du una formitara un ricura di ancient Mardinal			
007311	Polypeptide 6) (Eg Drug Metabolism) Gene Analysis	MP Criteria: Procedures/services reviewed against Medical			
0072U	Targeted Sequence Analysis (le Cyp2D6-2D7 Hybrid Gene)	Policy Criteria. Submit for Recommended Clinical Review to	_	-	_
	(List Separately In Addition To Code For Primary Procedure)	avoid post-service review by Carelon.			
	Cyp2D6 (Cytochrome P450 Family 2 Subfamily D				
	Polypeptide 6) (Eg Drug Metabolism) Gene Analysis	MP Criteria: Procedures/services reviewed against Medical			
0073U	Targeted Sequence Analysis (le Cyp2D7-2D6 Hybrid Gene)	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	(List Separately In Addition To Code For Primary Procedure)	avoid post-service review by Carelon.			
	Cyp2D6 (Cytochrome P450 Family 2 Subfamily D				
	Polypeptide 6) (Eg Drug Metabolism) Gene Analysis	MP Criteria: Procedures/services reviewed against Medical			
0074U	Targeted Sequence Analysis (le Non-Duplicated Gene When	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Duplication/Multiplication Is Trans) (List Separately In	avoid post-service review by Carelon.			
	Addition To Code For Primary Procedure)				
	Transcatheter Placement Of Extracranial Vertebral Artery	MP Criteria: Procedure/service reviewed against Medical			
0075T	Stent(S) Including Radiologic Supervision And Interpretation	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Open Or Percutaneous; Initial Vessel	avoid post-service review.			
	Cyp2D6 (Cytochrome P450 Family 2 Subfamily D				
	Polypeptide 6) (Eg Drug Metabolism) Gene Analysis	MP Criteria: Procedures/services reviewed against Medical			
0075U	Targeted Sequence Analysis (le 5' Gene	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Duplication/Multiplication) (List Separately In Addition To	avoid post-service review by Carelon.			
	Code For Primary Procedure)				
	Transcatheter Placement Of Extracranial Vertebral Artery				
	Stent(S) Including Radiologic Supervision And Interpretation	MP Criteria: Procedure/service reviewed against Medical			
0076T	Open Or Percutaneous; Each Additional Vessel (List	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Separately In Addition To Code For Primary Procedure)	avoid post-service review.			

	Cyp2D6 (Cytochrome P450 Family 2 Subfamily D				
	Polypeptide 6) (Eg Drug Metabolism) Gene Analysis	MP Criteria: Procedures/services reviewed against Medical			
0076U	Targeted Sequence Analysis (le 3' Gene Duplication/	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Multiplication) (List Separately In Addition To Code For	avoid post-service review by Carelon.			
	Primary Procedure)				
	Pain Management (Opioid-Use Disorder) Genotyping Panel				
	16 Common Variants (le Abcb1 Comt Dat1 Dbh Dor Drd1	MP Criteria: Procedures/services reviewed against Medical			
0078U	Drd2 Drd4 Gaba Gal Htr2A Httlpr Mthfr Muor Oprk1	Policy Criteria. Submit for Recommended Clinical Review to			
00700	Oprm1) Buccal Swab Or Other Germline Tissue Sample	avoid post-service review by Carelon.	_	_	_
	Algorithm Reported As Positive Or Negative Risk Of Opioid-	avoid post service review by earcion.			
	Use Disorder				
	Comparative Dna Analysis Using Multiple Selected Single-	MP Criteria: Procedures/services reviewed against Medical			
0079U	Nucleotide Polymorphisms (Snps) Urine And Buccal Dna Fo	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Specimen Identity Verification	avoid post-service review by Carelon.			
	Red Blood Cell Antigen Typing Dna Genotyping Of 10 Blood	Non Covered: Procedure/service not covered by the Plan.			
0084U	Groups With Phenotype Prediction Of 37 Red Blood Cell	Not subject to pre-service review.	_	_	_
	Antigens	not subject to pre service remem			
	Infectious Disease (Bacterial And Fungal) Organism				
	Identification Blood Culture Using Rrna Fish 6 Or More	Non Covered: Procedure/service not covered by the Plan.			
0086U	Organism Targets Reported As Positive Or Negative With	Not subject to pre-service review.	_	_	_
	Phenotypic Minimum Inhibitory Concentration (Mic)-Based	, , , , , , , , , , , , , , , , , , , ,			
	Antimicrobial Susceptibility				
	Cardiology (Heart Transplant) Mrna Gene Expression	MP Criteria: Procedures/services reviewed against Medical			
0087U	Profiling By Microarray Of 1283 Genes Transplant Biopsy	Policy Criteria. Submit for Recommended Clinical Review to			
	Tissue Allograft Rejection And Injury Algorithm Reported As	avoid post-service review by Carelon.	_	_	_
	A Probability Score				
	Transplantation Medicine (Kidney Allograft Rejection)	MP Criteria: Procedures/services reviewed against Medical			
0088U	Microarray Gene Expression Profiling Of 1494 Genes	Policy Criteria. Submit for Recommended Clinical Review to			
	Utilizing Transplant Biopsy Tissue Algorithm Reported As A	avoid post-service review by Carelon.	_		_
	Probability Score For Rejection	· ·			
000011	Oncology (Melanoma) Gene Expression Profiling By Rtqpcr	MP Criteria: Procedures/services reviewed against Medical			
0089U	Prame And Linc00518 Superficial Collection Using Adhesive	l e e e e e e e e e e e e e e e e e e e	-	-	_
	Patch(Es)	avoid post-service review by Carelon.			
	Oncology (Cutaneous Melanoma) Mrna Gene Expression	MP Criteria: Procedures/services reviewed against Medical			
000011	Profiling By Rt-Pcr Of 23 Genes (14 Content And 9	-			
0090U	Housekeeping) Utilizing Formalin-Fixed Paraffin-Embedded	Policy Criteria. Submit for Recommended Clinical Review to	-	-	_
	Tissue (Ffpe) Algorithm Reported As A Categorical Result (Ie	avoid post-service review by Careion.			
	Benign Intermediate Malignant) Oncology (Colorectal) Screening Cell Enumeration Of				
	5. (Non Covered: Procedure/service not covered by the Plan.			
0091U	Circulating Tumor Cells Utilizing Whole Blood Algorithm	Not subject to pre-service review.	_	_	_
	For The Presence Of Adenoma Or Cancer Reported As A	inot subject to pre-service review.			
	Positive Or Negative Result Oncology (Lung) Three Protein Biomarkers Immunoassay				
		Non Covered: Procedure/service not covered by the Plan.			
0092U	Using Magnetic Nanosensor Technology Plasma Algorithm	· ·	_	_	_
	Reported As Risk Score For Likelihood Of Malignancy	Not subject to pre-service review.			

0093U	Prescription Drug Monitoring Evaluation Of 65 Common Drugs By Lc-Ms/Ms Urine Each Drug Reported Detected Or Not Detected	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-
0094U	Genome (Eg Unexplained Constitutional Or Heritable Disorder Or Syndrome) Rapid Sequence Analysis	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
0095T	Removal Of Total Disc Arthroplasty (Artificial Disc) Anterior Approach Each Additional Interspace Cervical (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
0095U	Eosinophilic Esophagitis (Eotaxin-3 [Ccl26 {C-C Motif Chemokine Ligand 26}] And Major Basic Protein [Prg2 {Proteoglycan 2 Pro Eosinophil Major Basic Protein}] Enzyme-Linked Immunosorbent Assays (Elisa) Specimen Obtained By Esophageal String Test Device Algorithm Reported As Probability Of Active Or Inactive Eosinophilic Esophagitis	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	_
0096U		Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	-
0098Т	Revision Including Replacement Of Total Disc Arthroplasty (Artificial Disc) Anterior Approach Each Additional Interspace Cervical (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	-	_
0100T	Placement Of A Subconjunctival Retinal Prosthesis Receiver And Pulse Generator And Implantation Of Intraocular Retinal Electrode Array With Vitrectomy	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	-	-
0101T	Extracorporeal Shock Wave Involving Musculoskeletal System Not Otherwise Specified	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	-
0101U	Hereditary Colon Cancer Disorders (Eg Lynch Syndrome Pten Hamartoma Syndrome Cowden Syndrome Familial Adenomatosis Polyposis) Genomic Sequence Analysis Panel Utilizing A Combination Of Ngs Sanger Mlpa And Array Cgh With Mrna Analytics To Resolve Variants Of Unknown Significance When Indicated (15 Genes [Sequencing And Deletion/Duplication] Epcam And Grem1	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
0102T	Extracorporeal Shock Wave Performed By A Physician Requiring Anesthesia Other Than Local And Involving The Lateral Humeral Epicondyle	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	-	-
0102U	Hereditary Breast Cancer-Related Disorders (Eg Hereditary Breast Cancer Hereditary Ovarian Cancer Hereditary Endometrial Cancer) Genomic Sequence Analysis Panel Utilizing A Combination Of Ngs Sanger Mlpa And Array Cgh With Mrna Analytics To Resolve Variants Of Unknown Significance When Indicated (17 Genes [Sequencing And Deletion/Duplication])	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-

	Hereditary Ovarian Cancer (Eg Hereditary Ovarian Cancer	I			
	Hereditary Endometrial Cancer) Genomic Sequence Analysis				
	Panel Utilizing A Combination Of Ngs Sanger Mlpa And	MP Criteria: Procedures/services reviewed against Medical			
0103U		Policy Criteria. Submit for Recommended Clinical Review to			
01030	Array Cgh With Mrna Analytics To Resolve Variants Of	avoid post-service review by Carelon.	-	-	-
	Unknown Significance When Indicated (24 Genes	avoid post-service review by Careion.			
	[Sequencing And Deletion/Duplication] Epcam				
	[Deletion/Duplication Only])				
	Nephrology (Chronic Kidney Disease) Multiplex				
	Electrochemiluminescent Immunoassay (Eclia) Of Tumor				
	Necrosis Factor Receptor 1A Receptor Superfamily 2 (Tnfr1	New Covered Duesed and Jean See and severed by the Diese			
0105U	Tnfr2) And Kidney Injury Molecule-1 (Kim-1) Combined	Non Covered: Procedure/service not covered by the Plan.	_		
	With Longitudinal Clinical Data Including Apol1 Genotype If	Not subject to pre-service review.			
	Available And Plasma (Isolated Fresh Or Frozen) Algorithm				
	Reported As Probability Score For Rapid Kidney Function				
	Decline (Rkfd)	FILL Decord or / control of the models the Disc Not			
04.05	Quantitative Sensory Testing (Qst) Testing And	EIU: Procedure/service not reimbursed by the Plan. Not			
0106T	Interpretation Per Extremity; Using Touch Pressure Stimuli	subject to pre-service review. Check EIU policy, which is	_	_	-
	To Assess Large Diameter Sensation	one of our Clinical Payment and Coding Policy (CPCP).			
	Gastric Emptying Serial Collection Of 7 Timed Breath				
	Specimens Non-Radioisotope Carbon-13 (13C) Spirulina	EIU: Procedure/service not reimbursed by the Plan. Not			
0106U	Substrate Analysis Of Each Specimen By Gas Isotope Ratio	subject to pre-service review. Check EIU policy, which is	_	_	_
	Mass Spectrometry Reported As Rate Of 13Co2 Excretion	one of our Clinical Payment and Coding Policy (CPCP).			
	Quantitative Sensory Testing (Qst) Testing And	EIU: Procedure/service not reimbursed by the Plan. Not			
0107T	Interpretation Per Extremity; Using Vibration Stimuli To	subject to pre-service review. Check EIU policy, which is	_	_	_
	Assess Large Diameter Fiber Sensation	one of our Clinical Payment and Coding Policy (CPCP).			
	Clostridium Difficile Toxin(S) Antigen Detection By	Non Covered: Procedure/service not covered by the Plan.			
0107U	Immunoassay Technique Stool Qualitative Multiple-Step	Not subject to pre-service review.	_	_	_
	Method	Not subject to pre-service review.			
	Quantitative Sensory Testing (Qst) Testing And	EIU: Procedure/service not reimbursed by the Plan. Not			
0108T	Interpretation Per Extremity; Using Cooling Stimuli To Assess	subject to pre-service review. Check EIU policy, which is	_	_	_
	Small Nerve Fiber Sensation And Hyperalgesia	one of our Clinical Payment and Coding Policy (CPCP).			
	Gastroenterology (Barrett'S Esophagus) Whole Slide–Digital				
	Imaging Including Morphometric Analysis Computer-				
	Assisted Quantitative Immunolabeling Of 9 Protein	Non Covered: Procedure/service not covered by the Plan.			
0108U	Biomarkers (P16 Amacr P53 Cd68 Cox-2 Cd45Ro Hif1A	Not subject to pre-service review.	_	_	_
	Her-2 K20) And Morphology Formalin-Fixed Paraffin-	ivot subject to pre-service review.			
	Embedded Tissue Algorithm Reported As Risk Of				
	Progression To High-Grade Dysplasia Or Cancer				
	Quantitative Sensory Testing (Qst) Testing And	EIU: Procedure/service not reimbursed by the Plan. Not			
0109T	Interpretation Per Extremity; Using Heat-Pain Stimuli To	subject to pre-service review. Check EIU policy, which is	_	_	_
	Assess Small Nerve Fiber Sensation And Hyperalgesia	one of our Clinical Payment and Coding Policy (CPCP).			
	Infectious Disease (Aspergillus Species) Real-Time Pcr For				
	Detection Of Dna From 4 Species (A. Fumigatus A. Terreus	Non Covered: Procedure/service not covered by the Plan.			
0109U	A. Niger And A. Flavus) Blood Lavage Fluid Or Tissue	Not subject to pre-service review.	_	_	_
	Qualitative Reporting Of Presence Or Absence Of Each	inot subject to pre-service review.			
	Species				

	Quantitative Sensory Testing (Qst) Testing And	EIU: Procedure/service not reimbursed by the Plan. Not			
0110T	Interpretation Per Extremity; Using Other Stimuli To Assess	subject to pre-service review. Check EIU policy, which is			
0120.	Sensation	one of our Clinical Payment and Coding Policy (CPCP).	_	-	_
0110U	Prescription Drug Monitoring One Or More Oral Oncology Drug(S) And Substances Definitive Tandem Mass Spectrometry With Chromatography Serum Or Plasma From Capillary Blood Or Venous Blood Quantitative Report With Steady-State Range For The Prescribed Drug(S) When Detected	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	_
0111U	Formalin-Fixed Paraffin-Embedded Tissue	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
0112U	Infectious Agent Detection And Identification Targeted Sequence Analysis (16S And 18S Rrna Genes) With Drug-Resistance Gene	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	-	-
0113U	Oncology (Prostate) Measurement Of Pca3 And Tmprss2- Erg In Urine And Psa In Serum Following Prostatic Massage By Rna Amplification And Fluorescence-Based Detection Algorithm Reported As Risk Score	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
0114U	Gastroenterology (Barrett'S Esophagus) Vim And Ccna1 Methylation Analysis Esophageal Cells Algorithm Reported As Likelihood For Barrett'S Esophagus	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
0115U	Respiratory Infectious Agent Detection By Nucleic Acid (Dna And Rna) 18 Viral Types And Subtypes And 2 Bacterial Targets Amplified Probe Technique Including Multiplex Reverse Transcription For Rna Targets Each Analyte Reported As Detected Or Not Detected	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-
0116U	Prescription Drug Monitoring Enzyme Immunoassay Of 35 Or More Drugs Confirmed With Lc-Ms/Ms Oral Fluid Algorithm Results Reported As A Patient-Compliance Measurement With Risk Of Drug To Drug Interactions For Prescribed Medications	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-
0117U	Pain Management Analysis Of 11 Endogenous Analytes (Methylmalonic Acid Xanthurenic Acid Homocysteine Pyroglutamic Acid Vanilmandelate 5-Hydroxyindoleacetic Acid Hydroxymethylglutarate Ethylmalonate 3-Hydroxypropyl Mercapturic Acid (3-Hpma) Quinolinic Acid Kynurenic Acid) Lc-Ms/Ms Urine Algorithm Reported As A Pain-Index Score With Likelihood Of Atypical Biochemical Function Associated With Pain	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-
0118U	Transplantation Medicine Quantification Of Donor-Derived Cell-Free Dna Using Whole Genome Next-Generation Sequencing Plasma Reported As Percentage Of Donor-Derived Cell-Free Dna In The Total Cell-Free Dna	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	-	_

	Candialani, Caranidas Dulinuid Chramatananhi, Tandan				
	Cardiology Ceramides By Liquid Chromatography–Tandem	New Constant Description (see Section 1)			
0119U	Mass Spectrometry Plasma Quantitative Report With Risk	Non Covered: Procedure/service not covered by the Plan.			
	Score For Major Cardiovascular Events	Not subject to pre-service review.	_		_
	Oncology (B-Cell Lymphoma Classification) Mrna Gene				
	Expression Profiling By Fluorescent Probe Hybridization Of				
	58 Genes (45 Content And 13 Housekeeping Genes)	MP Criteria: Procedures/services reviewed against Medical			
0120U	Formalin-Fixed Paraffin-Embedded Tissue Algorithm	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Reported As Likelihood For Primary Mediastinal B-Cell	avoid post-service review by Carelon.			
	Lymphoma (Pmbcl) And Diffuse Large B-Cell Lymphoma				
	(Dlbcl) With Cell Of Origin Subtyping In The Latter				
0121U	Sickle Cell Disease Microfluidic Flow Adhesion (Vcam-1)	Non Covered: Procedure/service not covered by the Plan.			
01210	Whole Blood	Not subject to pre-service review.	-	-	-
0122U	Sickle Cell Disease Microfluidic Flow Adhesion (P-Selectin)	Non Covered: Procedure/service not covered by the Plan.			
01220	Whole Blood	Not subject to pre-service review.	-	-	-
0123U	Mechanical Fragility Rbc Shear Stress And Spectral Analysis	Non Covered: Procedure/service not covered by the Plan.			
01230	Profiling	Not subject to pre-service review.	-	-	-
	Hereditary Breast Cancer–Related Disorders (Eg Hereditary				
	Breast Cancer Hereditary Ovarian Cancer Hereditary	MP Criteria: Procedures/services reviewed against Medical			
0129U	Endometrial Cancer) Genomic Sequence Analysis And	Policy Criteria. Submit for Recommended Clinical Review to	_	_	-
	Deletion/Duplication Analysis Panel (Atm Brca1 Brca2	avoid post-service review by Carelon.			
	Cdh1 Chek2 Palb2 Pten And Tp53)				
	Hereditary Colon Cancer Disorders (Eg Lynch Syndrome				
	Pten Hamartoma Syndrome Cowden Syndrome Familial	MP Criteria: Procedures/services reviewed against Medical			
0130U	Adenomatosis Polyposis) Targeted Mrna Sequence Analysis	Policy Criteria. Submit for Recommended Clinical Review to			
	Panel (Apc Cdh1 Chek2 Mlh1 Msh2 Msh6 Mutyh Pms2	avoid post-service review by Carelon.	_	_	
	Pten And Tp53) (List Separately In Addition To Code For	, , , , , , , , , , , , , , , , , , , ,			
	Primary Procedure)				
	Hereditary Breast Cancer–Related Disorders (Eg Hereditary	NAD City in December 1 and the live to the second and the last			
042411	Breast Cancer Hereditary Ovarian Cancer Hereditary	MP Criteria: Procedures/services reviewed against Medical			
0131U	Endometrial Cancer) Targeted Mrna Sequence Analysis	Policy Criteria. Submit for Recommended Clinical Review to	-	-	-
	Panel (13 Genes) (List Separately In Addition To Code For	avoid post-service review by Carelon.			
	Primary Procedure)				
	Hereditary Ovarian Cancer–Related Disorders (Eg	MP Criteria: Procedures/services reviewed against Medical			
0132U	Hereditary Breast Cancer Hereditary Ovarian Cancer	Policy Criteria. Submit for Recommended Clinical Review to			
01320	Hereditary Endometrial Cancer) Targeted Mrna Sequence	· ·	_	-	-
	Analysis Panel (17 Genes) (List Separately In Addition To	avoid post-service review by Carelon.			
	Code For Primary Procedure) Hereditary Prostate Cancer–Related Disorders Targeted	MP Criteria: Procedures/services reviewed against Medical			
0133U	Mrna Sequence Analysis Panel (11 Genes) (List Separately In				
01330	Addition To Code For Primary Procedure)	avoid post-service review by Carelon.	-	-	-
	Hereditary Pan Cancer (Eg Hereditary Breast And Ovarian	avoid post-service review by careion.			
	Cancer Hereditary Endometrial Cancer Hereditary	MP Criteria: Procedures/services reviewed against Medical			
0134U	Colorectal Cancer) Targeted Mrna Sequence Analysis Panel	Policy Criteria. Submit for Recommended Clinical Review to			
	(18 Genes) (List Separately In Addition To Code For Primary	avoid post-service review by Carelon.	-	-	-
	Procedure)	avoid post service review by edicion.			
	i i occuule)	·			

	Hereditary Gynecological Cancer (Eg Hereditary Breast And Ovarian Cancer Hereditary Endometrial Cancer Hereditary	MP Criteria: Procedures/services reviewed against Medical			
0135U	Colorectal Cancer) Targeted Mrna Sequence Analysis Panel	Policy Criteria. Submit for Recommended Clinical Review to			
01330	(12 Genes) (List Separately In Addition To Code For Primary	avoid post-service review by Carelon.	_	-	_
	Procedure)	avoid post-service review by Carelon.			
	Atm (Ataxia Telangiectasia Mutated) (Eg Ataxia	MP Criteria: Procedures/services reviewed against Medical			
0136U	Telangiectasia) Mrna Sequence Analysis (List Separately In	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Addition To Code For Primary Procedure)	avoid post-service review by Carelon.			
	Palb2 (Partner And Localizer Of Brca2) (Eg Breast And	MP Criteria: Procedures/services reviewed against Medical			
0137U	Pancreatic Cancer) Mrna Sequence Analysis (List Separately	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	In Addition To Code For Primary Procedure)	avoid post-service review by Carelon.			
	Brca1 (Brca1 Dna Repair Associated) Brca2 (Brca2 Dna	MP Criteria: Procedures/services reviewed against Medical			
0138U	Repair Associated) (Eg Hereditary Breast And Ovarian	Policy Criteria. Submit for Recommended Clinical Review to			
02300	Cancer) Mrna Sequence Analysis (List Separately In Addition	avoid post-service review by Carelon.	_	_	_
	To Code For Primary Procedure)				
	Infectious Disease (Fungi) Fungal Pathogen Identification				
0140U	Dna (15 Fungal Targets) Blood Culture Amplified Probe	Non Covered: Procedure/service not covered by the Plan.			
	Technique Each Target Reported As Detected Or Not	Not subject to pre-service review.	_	_	_
	Detected				
	Infectious Disease (Bacteria And Fungi) Gram-Positive	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.			
	Organism Identification And Drug Resistance Element				
04.4411	Detection Dna (20 Gram-Positive Bacterial Targets 4				
0141U	Resistance Genes 1 Pan Gram-Negative Bacterial Target 1		_	-	-
	Pan Candida Target) Blood Culture Amplified Probe				
	Technique Each Target Reported As Detected Or Not				
	Detected Infectious Disease (Pasteria And Funcil) Cram Positive				
	Infectious Disease (Bacteria And Fungi) Gram-Positive				
	Organism Identification And Drug Resistance Element				
0142U	Detection Dna (20 Gram-Positive Bacterial Targets 4	Non Covered: Procedure/service not covered by the Plan.			
01420	Resistance Genes 1 Pan Gram-Negative Bacterial Target 1	Not subject to pre-service review.	_	-	-
	Pan Candida Target) Blood Culture Amplified Probe				
	Technique Each Target Reported As Detected Or Not				
	Detected Infectious Disease (Bacteria Fungi Parasites And Dna				
	Viruses) Microbial Cell-Free Dna Plasma Untargeted Next-	Non Covered: Procedure/service not covered by the Plan.			
0152U	Generation Sequencing Report For Significant Positive	Not subject to pre-service review.	_	_	_
	Pathogens	not subject to pre-service review.			
	Oncology (Breast) Mrna Gene Expression Profiling By Next-				
	Generation Sequencing Of 101 Genes Utilizing Formalin-	MP Criteria: Procedures/services reviewed against Medical			
0153U	Fixed Paraffin-Embedded Tissue Algorithm Reported As A	Policy Criteria. Submit for Recommended Clinical Review to			
	Triple Negative Breast Cancer Clinical Subtype(S) With	avoid post-service review by Carelon.	_	_	-
	Information On Immune Cell Involvement				
	information on infinite centification	!			

0154U	Oncology (Urothelial Cancer) Rna Analysis By Real-Time Rt-Pcr Of The Fgfr3 (Fibroblast Growth Factor Receptor 3) Gene Analysis (Ie P.R248C [C.742C>T] P.S249C [C.746C>G] P.G370C [C.1108G>T] P.Y373C [C.1118A>G] Fgfr3-Tacc3V1 And Fgfr3-Tacc3V3) Utilizing Formalin-Fixed Paraffin-Embedded Urothelial Cancer Tumor Tissue Reported As Fgfr Gene Alteration Status	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	_
0155U	Oncology (Breast Cancer) Dna Pik3Ca (Phosphatidylinositol- 4 5-Bisphosphate 3-Kinase Catalytic Subunit Alpha) (Eg Breast Cancer) Gene Analysis (Ie P.C420R P.E542K P.E545A P.E545D [G.1635G>T Only] P.E545G P.E545K P.Q546E P.Q546R P.H1047L P.H1047R P.H1047Y) Utilizing Formalin- Fixed Paraffin-Embedded Breast Tumor Tissue Reported As Pik3Ca Gene Mutation Status	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	_	-
0156U	Copy Number (Eg Intellectual Disability Dysmorphology) Sequence Analysis	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
0157U	Apc (Apc Regulator Of Wnt Signaling Pathway) (Eg Familial Adenomatosis Polyposis [Fap]) Mrna Sequence Analysis (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
0158U	Mlh1 (Mutl Homolog 1) (Eg Hereditary Non-Polyposis Colorectal Cancer Lynch Syndrome) Mrna Sequence Analysis (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
0159U	Msh2 (Muts Homolog 2) (Eg Hereditary Colon Cancer Lynch Syndrome) Mrna Sequence Analysis (List Separately In Addition To Code For Procedure)	Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
0160U	Msh6 (Muts Homolog 6) (Eg Hereditary Colon Cancer Lynch Syndrome) Mrna Sequence Analysis (List Separately In Addition To Code For Primary Procedure)	Policy Criteria: Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	-	-
0161U	Pms2 (Pms1 Homolog 2 Mismatch Repair System Component) (Eg Hereditary Non-Polyposis Colorectal Cancer Lynch Syndrome) Mrna Sequence Analysis (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
0162U	Hereditary Colon Cancer (Lynch Syndrome) Targeted Mrna Sequence Analysis Panel (Mlh1 Msh2 Msh6 Pms2) (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
0164T	Removal Of Total Disc Arthroplasty (Artificial Disc) Anterior Approach Each Additional Interspace Lumbar (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-

0165T	Revision Including Replacement Of Total Disc Arthroplasty (Artificial Disc) Anterior Approach Each Additional Interspace Lumbar (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_	-
0169U	Nudt15 (Nudix Hydrolase 15) And Tpmt (Thiopurine S- Methyltransferase) (Eg Drug Metabolism) Gene Analysis Common Variants	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
0170U	Neurology (Autism Spectrum Disorder [Asd]) Rna Next- Generation Sequencing Saliva Algorithmic Analysis And Results Reported As Predictive Probability Of Asd Diagnosis	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	-	-
0171U	Targeted Genomic Sequence Analysis Panel Acute Myeloid Leukemia Myelodysplastic Syndrome And Myeloproliferative Neoplasms Dna Analysis 23 Genes Interrogation For Sequence Variants Rearrangements And Minimal Residual Disease Reported As Presence/Absence	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
0198T	Measurement Of Ocular Blood Flow By Repetitive Intraocular Pressure Sampling With Interpretation And Report	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
0200Т	Percutaneous Sacral Augmentation (Sacroplasty) Unilateral Injection(S) Including The Use Of A Balloon Or Mechanical Device When Used 1 Or More Needles Includes Imaging Guidance And Bone Biopsy When Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2024	-	Add effective 01/01/2024
0201T	Percutaneous Sacral Augmentation (Sacroplasty) Bilateral Injections Including The Use Of A Balloon Or Mechanical Device When Used 2 Or More Needles Includes Imaging Guidance And Bone Biopsy When Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2024	-	Add effective 01/01/2024
0202Т	Posterior Vertebral Joint(S) Arthroplasty (Eg Facet Joint[S] Replacement) Including Facetectomy Laminectomy Foraminotomy And Vertebral Column Fixation Injection Of Bone Cement When Performed Including Fluoroscopy Single Level Lumbar Spine	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
0203U	Autoimmune (Inflammatory Bowel Disease) Mrna Gene Expression Profiling By Quantitative Rt-Pcr 17 Genes (15 Target And 2 Reference Genes) Whole Blood Reported As A Continuous Risk Score And Classification Of Inflammatory Bowel Disease Aggressiveness	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
0204U	Oncology (Thyroid) Mrna Gene Expression Analysis Of 593 Genes (Including Braf Ras Ret Pax8 And Ntrk) For Sequence Variants And Rearrangements Utilizing Fine Needle Aspirate Reported As Detected Or Not Detected	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-

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0205U	Ophthalmology (Age-Related Macular Degeneration) Analysis Of 3 Gene Variants (2 Cfh Gene 1 Arms2 Gene) Using Pcr And Maldi-Tof Buccal Swab Reported As Positive Or Negative For Neovascular Age-Related Macular- Degeneration Risk Associated With Zinc Supplements	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_	_
0207T	Evacuation Of Meibomian Glands Automated Using Heat And Intermittent Pressure Unilateral	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
0209U	Cytogenomic Constitutional (Genome-Wide) Analysis Interrogation Of Genomic Regions For Copy Number Structural Changes And Areas Of Homozygosity For Chromosomal Abnormalities	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
0211U	Oncology (Pan-Tumor) Dna And Rna By Next-Generation Sequencing Utilizing Formalin-Fixed Paraffin-Embedded Tissue Interpretative Report For Single Nucleotide Variants Copy Number Alterations Tumor Mutational Burden And Microsatellite Instability With Therapy Association	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
0212U	Rare Diseases (Constitutional/Heritable Disorders) Whole Genome And Mitochondrial Dna Sequence Analysis Including Small Sequence Changes Deletions Duplications Short Tandem Repeat Gene Expansions And Variants In Non Uniquely Mappable Regions Blood Or Saliva Identification And Categorization Of Genetic Variants Proband	MP Criteria: Procedures/services reviewed against Medical - Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
0213T	Injection(S) Diagnostic Or Therapeutic Agent Paravertebral Facet (Zygapophyseal) Joint (Or Nerves Innervating That Joint) With Ultrasound Guidance Cervical Or Thoracic; Single Level	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
0213U	Rare Diseases (Constitutional/Heritable Disorders) Whole Genome And Mitochondrial Dna Sequence Analysis Including Small Sequence Changes Deletions Duplications Short Tandem Repeat Gene Expansions And Variants In Non Uniquely Mappable Regions Blood Or Saliva Identification And Categorization Of Genetic Variants Each Comparator Genome (Eg. Parent. Sibling)	MP Criteria: Procedures/services reviewed against Medical - Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
0214T	Injection(S) Diagnostic Or Therapeutic Agent Paravertebral Facet (Zygapophyseal) Joint (Or Nerves Innervating That Joint) With Ultrasound Guidance Cervical Or Thoracic; Second Level (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-

0214U	Rare Diseases (Constitutional/Heritable Disorders) Whole Exome And Mitochondrial Dna Sequence Analysis Including Small Sequence Changes Deletions Duplications Short Tandem Repeat Gene Expansions And Variants In Non-Uniquely Mappable Regions Blood Or Saliva Identification And Categorization Of Genetic Variants Proband	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
0215T	Injection(S) Diagnostic Or Therapeutic Agent Paravertebral Facet (Zygapophyseal) Joint (Or Nerves Innervating That Joint) With Ultrasound Guidance Cervical Or Thoracic; Third And Any Additional Level(S) (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	_
0215U	Rare Diseases (Constitutional/Heritable Disorders) Whole Exome And Mitochondrial Dna Sequence Analysis Including Small Sequence Changes Deletions Duplications Short Tandem Repeat Gene Expansions And Variants In Non-Uniquely Mappable Regions Blood Or Saliva Identification And Categorization Of Genetic Variants Each Comparator Exome (Eg. Parent Sibling)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	_
0216T	Injection(S) Diagnostic Or Therapeutic Agent Paravertebral Facet (Zygapophyseal) Joint (Or Nerves Innervating That Joint) With Ultrasound Guidance Lumbar Or Sacral; Single Level	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
0216U	Neurology (Inherited Ataxias) Genomic Dna Sequence Analysis Of 12 Common Genes Including Small Sequence Changes Deletions Duplications Short Tandem Repeat Gene Expansions And Variants In Non-Uniquely Mappable Regions Blood Or Saliva Identification And Categorization Of Genetic Variants	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
0217T	Injection(S) Diagnostic Or Therapeutic Agent Paravertebral Facet (Zygapophyseal) Joint (Or Nerves Innervating That Joint) With Ultrasound Guidance Lumbar Or Sacral; Second Level (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	_
0217U	Neurology (Inherited Ataxias) Genomic Dna Sequence Analysis Of 51 Genes Including Small Sequence Changes Deletions Duplications Short Tandem Repeat Gene Expansions And Variants In Non-Uniquely Mappable Regions Blood Or Saliva Identification And Categorization Of Genetic Variants	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
0218T	Injection(S) Diagnostic Or Therapeutic Agent Paravertebral Facet (Zygapophyseal) Joint (Or Nerves Innervating That Joint) With Ultrasound Guidance Lumbar Or Sacral; Third And Any Additional Level(S) (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-

	Neurology (Muscular Dystrophy) Dmd Gene Sequence				
	Analysis Including Small Sequence Changes Deletions	MP Criteria: Procedures/services reviewed against Medical			
0218U	Duplications And Variants In Non-Uniquely Mappable	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Regions Blood Or Saliva Identification And Characterization	avoid post-service review by Carelon.			
	Of Genetic Variants				
	Placement Of A Posterior Intrafacet Implant(S) Unilateral Or	EIU: Procedure/service not reimbursed by the Plan. Not			
0219T	Bilateral Including Imaging And Placement Of Bone Graft(S)	subject to pre-service review. Check EIU policy, which is	_		_
	Or Synthetic Device(S) Single Level; Cervical	one of our Clinical Payment and Coding Policy (CPCP).			
	Placement Of A Posterior Intrafacet Implant(S) Unilateral Or	EIU: Procedure/service not reimbursed by the Plan. Not			
0220T	Bilateral Including Imaging And Placement Of Bone Graft(S)				
	Or Synthetic Device(S) Single Level; Thoracic	one of our Clinical Payment and Coding Policy (CPCP).			
	Placement Of A Posterior Intrafacet Implant(S) Unilateral Or	EIU: Procedure/service not reimbursed by the Plan. Not			
0221T		subject to pre-service review. Check EIU policy, which is	_		
	Or Synthetic Device(S) Single Level; Lumbar	one of our Clinical Payment and Coding Policy (CPCP).			
	Placement Of A Posterior Intrafacet Implant(S) Unilateral Or				
		EIU: Procedure/service not reimbursed by the Plan. Not			
0222T	Or Synthetic Device(S) Single Level; Each Additional	subject to pre-service review. Check EIU policy, which is			
	Vertebral Segment (List Separately In Addition To Code For	one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
	Primary Procedure)				
	Antibody Severe Acute Respiratory Syndrome Coronavirus 2	EIU: Procedure/service not reimbursed by the Plan. Not			
0224U	(Sars-Cov-2) (Coronavirus Disease [Covid-19]) Includes	subject to pre-service review. Check EIU policy, which is			
	Titer(S) When Performed	one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
	Surrogate Viral Neutralization Test (Svnt) Severe Acute	EIU: Procedure/service not reimbursed by the Plan. Not			
0226U	Respiratory Syndrome Coronavirus 2 (Sars-Cov-2)	subject to pre-service review. Check EIU policy, which is			
	(Coronavirus Disease [Covid-19]) Elisa Plasma Seru	one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
	Oncology (Prostate) Multianalyte Molecular Profile By				
	Photometric Detection Of Macromolecules Adsorbed On	MP Criteria: Procedures/services reviewed against Medical			
0228U	Nanosponge Array Slides With Machine Learning Utilizing	Policy Criteria. Submit for Recommended Clinical Review to			
	First Morning Voided Urine Algorithm Reported As	avoid post-service review by Carelon.	_	_	-
	Likelihood Of Prostate Cancer	arola post service remem sy careloni			
	Bcat1 (Branched Chain Amino Acid Transaminase 1) And	MP Criteria: Procedures/services reviewed against Medical			
0229U	Ikzf1 (Ikaros Family Zinc Finger 1) (Eg Colorectal Cancer)	Policy Criteria. Submit for Recommended Clinical Review to			
02230	Promoter Methylation Analysis	avoid post-service review by Carelon.	_	-	-
	Ar (Androgen Receptor) (Eg. Spinal And Bulbar Muscular	avoid post service review by carcion.			
	Atrophy Kennedy Disease X Chromosome Inactivation) Full				
	Sequence Analysis Including Small Sequence Changes In	MP Criteria: Procedures/services reviewed against Medical			
0230U	Exonic And Intronic Regions Deletions Duplications Short	Policy Criteria. Submit for Recommended Clinical Review to			
02300	Tandem Repeat (Str) Expansions Mobile Element Insertions	•	_	-	-
		avoid post service review by carcion.			
	And Variants In Non-Uniquely Mappable Regions				
	Cacna1A (Calcium Voltage-Gated Channel Subunit Alpha 1A)				
	(Eg Spinocerebellar Ataxia) Full Gene Analysis Including				
	Small Sequence Changes In Exonic And Intronic Regions	MP Criteria: Procedures/services reviewed against Medical			
0231U	Deletions Duplications Short Tandem Repeat (Str) Gene	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by Carelon.			
	Expansions Mobile Element Insertions And Variants In Non-				
	Uniquely Mappable Regions			<u> </u>	

	Injection(S) Platelet Rich Plasma Any Site Including Image	EIU: Procedure/service not reimbursed by the Plan. Not			
0232T	Guidance Harvesting And Preparation When Performed	subject to pre-service review. Check EIU policy, which is			
	, , , , , , , , , , , , , , , , , , ,	one of our Clinical Payment and Coding Policy (CPCP).	_	_	<u> </u>
0232U	Cstb (Cystatin B) (Eg Progressive Myoclonic Epilepsy Type 1A Unverricht-Lundborg Disease) Full Gene Analysis Including Small Sequence Changes In Exonic And Intronic Regions Deletions Duplications Short Tandem Repeat (Str) Expansions Mobile Element Insertions And Variants In Non- Uniquely Mappable Regions Fxn (Frataxin) (Eg Friedreich Ataxia) Gene Analysis	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_	-
0233U	Including Small Sequence Changes In Exonic And Intronic Regions Deletions Duplications Short Tandem Repeat (Str) Expansions Mobile Element Insertions And Variants In Non- Uniquely Mappable Regions	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_	_
0234U	Mecp2 (Methyl Cpg Binding Protein 2) (Eg Rett Syndrome) Full Gene Analysis Including Small Sequence Changes In Exonic And Intronic Regions Deletions Duplications Mobile Element Insertions And Variants In Non-Uniquely Mappable Regions		-	-	-
0235U	Pten (Phosphatase And Tensin Homolog) (Eg Cowden Syndrome Pten Hamartoma Tumor Syndrome) Full Gene Analysis Including Small Sequence Changes In Exonic And Intronic Regions Deletions Duplications Mobile Element Insertions And Variants In Non-Uniquely Mappable Regions	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	-	-
0236U	Smn1 (Survival Of Motor Neuron 1 Telomeric) And Smn2 (Survival Of Motor Neuron 2 Centromeric) (Eg Spinal Muscular Atrophy) Full Gene Analysis Including Small Sequence Changes In Exonic And Intronic Regions Duplications Deletions And Mobile Element Insertions	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
0237U	Cardiac Ion Channelopathies (Eg Brugada Syndrome Long Qt Syndrome Short Qt Syndrome Catecholaminergic Polymorphic Ventricular Tachycardia) Genomic Sequence Analysis Panel Including Ank2 Casq2 Cav3 Kcne1 Kcne2 Kcnh2 Kcnj2 Kcnq1 Ryr2 And Scn5A Including Small Sequence Changes In Exonic And Intronic Regions Deletions Duplications Mobile Element Insertions And Variants In Non-Uniquely Mappable Regions	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_	-
0238U	Oncology (Lynch Syndrome) Genomic Dna Sequence Analysis Of Mlh1 Msh2 Msh6 Pms2 And Epcam Including Small Sequence Changes In Exonic And Intronic Regions Deletions Duplications Mobile Element Insertions And Variants In Non-Uniquely Mappable Regions	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-

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0239U	Targeted Genomic Sequence Analysis Panel Solid Organ Neoplasm Cell-Free Dna Analysis Of 311 Or More Genes Interrogation For Sequence Variants Including Substitutions	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Insertions Deletions Select Rearrangements And Copy Number Variations	avoid post-service review by Carelon.			
0242U	Targeted Genomic Sequence Analysis Panel Solid Organ Neoplasm Cell-Free Circulating Dna Analysis Of 55-74 Genes Interrogation For Sequence Variants Gene Copy Number Amplifications And Gene Rearrangements	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
0244U	Oncology (Solid Organ) Dna Comprehensive Genomic Profiling 257 Genes Interrogation For Single-Nucleotide Variants Insertions/Deletions Copy Number Alterations Gene Rearrangements Tumor-Mutational Burden And Microsatellite Instability Utilizing Formalin-Fixed Paraffin-Embedded Tumor Tissue	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
0245U	Oncology (Thyroid) Mutation Analysis Of 10 Genes And 37 Rna Fusions And Expression Of 4 Mrna Markers Using Next- Generation Sequencing Fine Needle Aspirate Report Includes Associated Risk Of Malignancy Expressed As A Percentage	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	_	-
0250U	Oncology (Solid Organ Neoplasm) Targeted Genomic Sequence Dna Analysis Of 505 Genes Interrogation For Somatic Alterations (Snvs [Single Nucleotide Variant] Small Insertions And Deletions One Amplification And Four Translocations) Microsatellite Instability And Tumor-Mutation Burden	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
0252U	Fetal Aneuploidy Short Tandem–Repeat Comparative Analysis Fetal Dna From Products Of Conception Reported As Normal (Euploidy) Monosomy Trisomy Or Partial Deletion/Duplication Mosaicism And Segmental Aneuploidy	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
0253T	Insertion Of Anterior Segment Aqueous Drainage Device Without Extraocular Reservoir Internal Approach Into The Suprachoroidal Space	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	-	_	-
0253U	Reproductive Medicine (Endometrial Receptivity Analysis) Rna Gene Expression Profile 238 Genes By Next-Generation Sequencing Endometrial Tissue Predictive Algorithm Reported As Endometrial Window Of Implantation (Eg Pre- Receptive Receptive Post-Receptive)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-

0254U	Reproductive Medicine (Preimplantation Genetic Assessment) Analysis Of 24 Chromosomes Using Embryonic Dna Genomic Sequence Analysis For Aneuploidy And A Mitochondrial Dna Score In Euploid Embryos Results Reported As Normal (Euploidy) Monosomy Trisomy Or Partial Deletion/Duplication Mosaicism And Segmental Aneuploidy Per Embryo Tested	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
0258U	Autoimmune (Psoriasis) Mrna Next-Generation Sequencing Gene Expression Profiling Of 50-100 Genes Skin-Surface Collection Using Adhesive Patch Algorithm Reported As Likelihood Of Response To Psoriasis Biologics	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
0260U	Rare Diseases (Constitutional/Heritable Disorders) Identification Of Copy Number Variations Inversions Insertions Translocations And Other Structural Variants By Optical Genome Mapping	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
0262U	Oncology (Solid Tumor) Gene Expression Profiling By Real- Time Rt-Pcr Of 7 Gene Pathways (Er Ar Pi3K Mapk Hh Tgfb Notch) Formalin-Fixed Paraffin-Embedded (Ffpe) Algorithm Reported As Gene Pathway Activity Score	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
0263Т	Intramuscular Autologous Bone Marrow Cell Therapy With Preparation Of Harvested Cells Multiple Injections One Leg Including Ultrasound Guidance If Performed; Complete Procedure Including Unilateral Or Bilateral Bone Marrow Harvest	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
0264T	Intramuscular Autologous Bone Marrow Cell Therapy With Preparation Of Harvested Cells Multiple Injections One Leg Including Ultrasound Guidance If Performed; Complete Procedure Excluding Bone Marrow Harvest	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
0264U	Rare Diseases (Constitutional/Heritable Disorders) Identification Of Copy Number Variations Inversions Insertions Translocations And Other Structural Variants By Optical Genome Mapping	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
0265T	Intramuscular Autologous Bone Marrow Cell Therapy With Preparation Of Harvested Cells Multiple Injections One Leg Including Ultrasound Guidance If Performed; Unilateral Or Bilateral Bone Marrow Harvest Only For Intramuscular Autologous Bone Marrow Cell Therapy	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
0265U	Rare Constitutional And Other Heritable Disorders Whole Genome And Mitochondrial Dna Sequence Analysis Blood Frozen And Formalin-Fixed Paraffin-Embedded (Ffpe) Tissue Saliva Buccal Swabs Or Cell Lines Identification Of Single Nucleotide And Copy Number Variants	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	_

	Implantation Or Replacement Of Carotid Sinus Baroreflex				
	Activation Device; Total System (Includes Generator	MP Criteria: Procedure/service reviewed against Medical			
0266T	Placement Unilateral Or Bilateral Lead Placement Intra-	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Operative Interrogation Programming And Repositioning	avoid post-service review.			
	When Performed)				
	Unexplained Constitutional Or Other Heritable Disorders Or				
	Syndromes Tissue-Specific Gene Expression By Whole-	MP Criteria: Procedures/services reviewed against Medical			
036611	Transcriptome And Next-Generation Sequencing Blood	·			
0266U	Formalin-Fixed Paraffin-Embedded (Ffpe) Tissue Or Fresh	Policy Criteria. Submit for Recommended Clinical Review to	_	-	-
	Frozen Tissue Reported As Presence Or Absence Of Splicing	avoid post-service review by Carelon.			
	Or Expression Changes				
	Implantation Or Replacement Of Carotid Sinus Baroreflex	NAD Criteria: Dragadura / aprila project de aprila de Nadicel			
00.577	Activation Device; Lead Only Unilateral (Includes Intra-	MP Criteria: Procedure/service reviewed against Medical			
0267T	Operative Interrogation Programming And Repositioning	Policy Criteria. Submit for Recommended Clinical Review to	_	_	-
	When Performed)	avoid post-service review.			
	Rare Constitutional And Other Heritable Disorders				
	Identification Of Copy Number Variations Inversions	MP Criteria: Procedures/services reviewed against Medical			
0267U	Insertions Translocations And Other Structural Variants By	Policy Criteria. Submit for Recommended Clinical Review to			
	Optical Genome Mapping And Whole Genome Sequencing	avoid post-service review by Carelon.	_		_
	characteristics with the second control of t	, ,			
	Implantation Or Replacement Of Carotid Sinus Baroreflex				
	Activation Device; Pulse Generator Only (Includes Intra-	MP Criteria: Procedure/service reviewed against Medical			
0268T	Operative Interrogation Programming And Repositioning	Policy Criteria. Submit for Recommended Clinical Review to	_	_	-
	When Performed)	avoid post-service review.			
	Hematology (Atypical Hemolytic Uremic Syndrome [Ahus])	MP Criteria: Procedures/services reviewed against Medical			
0268U	Genomic Sequence Analysis Of 15 Genes Blood Buccal	Policy Criteria. Submit for Recommended Clinical Review to			
	Swab Or Amniotic Fluid	avoid post-service review by Carelon.	_		_
	Revision Or Removal Of Carotid Sinus Baroreflex Activation				
	Device; Total System (Includes Generator Placement	MP Criteria: Procedure/service reviewed against Medical			
0269T	Unilateral Or Bilateral Lead Placement Intra-Operative	Policy Criteria. Submit for Recommended Clinical Review to			
	Interrogation Programming And Repositioning When	avoid post-service review.	_	_	[
	Performed)				
	Hematology (Autosomal Dominant Congenital	MP Criteria: Procedures/services reviewed against Medical			
0269U	Thrombocytopenia) Genomic Sequence Analysis Of 22	Policy Criteria. Submit for Recommended Clinical Review to			
	Genes Blood Buccal Swab Or Amniotic Fluid	avoid post-service review by Carelon.	-	_	_
	Revision Or Removal Of Carotid Sinus Baroreflex Activation				
	Device; Lead Only Unilateral (Includes Intra-Operative	MP Criteria: Procedure/service reviewed against Medical			
0270T	Interrogation Programming And Repositioning When	Policy Criteria. Submit for Recommended Clinical Review to	_	_	-
	Performed)	avoid post-service review.			
	Hematology (Congenital Coagulation Disorders) Genomic	MP Criteria: Procedures/services reviewed against Medical			
0270U	Sequence Analysis Of 20 Genes Blood Buccal Swab Or	Policy Criteria. Submit for Recommended Clinical Review to			
	Amniotic Fluid	avoid post-service review by Carelon.	_	-	-
	Revision Or Removal Of Carotid Sinus Baroreflex Activation				
	Device; Pulse Generator Only (Includes Intra-Operative	MP Criteria: Procedure/service reviewed against Medical			
0271T		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Interrogation Programming And Repositioning When	avoid post-service review.			
	Performed)			1	

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0271U	Hematology (Congenital Neutropenia) Genomic Sequence Analysis Of 24 Genes Blood Buccal Swab Or Amniotic Fluid	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to	-	-	-
0272Т	Interrogation Device Evaluation (In Person) Carotid Sinus Baroreflex Activation System Including Telemetric Iterative Communication With The Implantable Device To Monitor Device Diagnostics And Programmed Therapy Values With Interpretation And Report (Eg Battery Status Lead Impedance Pulse Amplitude Pulse Width Therapy Frequency Pathway Mode Burst Mode Therapy Start/Stop Times Each Day):	avoid post-service review by Carelon. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	-	_	_
0272U	Hematology (Genetic Bleeding Disorders) Genomic Sequence Analysis Of 60 Genes And Duplication/Deletion Of Plau Blood Buccal Swab Or Amniotic Fluid Comprehensive	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
0273T	Interrogation Device Evaluation (In Person) Carotid Sinus Baroreflex Activation System Including Telemetric Iterative Communication With The Implantable Device To Monitor Device Diagnostics And Programmed Therapy Values With Interpretation And Report (Eg Battery Status Lead Impedance Pulse Amplitude Pulse Width Therapy Frequency Pathway Mode Burst Mode Therapy Start/Stop Times Each Day): With Programming	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	-	-	-
0273U	Hematology (Genetic Hyperfibrinolysis Delayed Bleeding) Genomic Sequence Analysis Of 8 Genes (F13A1 F13B Fga Fgb Fgg Serpina1 Serpine1 Serpinf2 Plau) Blood Buccal Swab Or Amniotic Fluid	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	_	-
0274T	Percutaneous Laminotomy/Laminectomy (Interlaminar Approach) For Decompression Of Neural Elements (With Or Without Ligamentous Resection Discectomy Facetectomy And/Or Foraminotomy) Any Method Under Indirect Image Guidance (Eg Fluoroscopic Ct) Single Or Multiple Levels Unilateral Or Bilateral; Cervical Or Thoracic	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	_
0274U	Hematology (Genetic Platelet Disorders) Genomic Sequence Analysis Of 62 Genes And Duplication/Deletion Of Plau Blood Buccal Swab Or Amniotic Fluid	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
0275T	Percutaneous Laminotomy/Laminectomy (Interlaminar Approach) For Decompression Of Neural Elements (With Or Without Ligamentous Resection Discectomy Facetectomy And/Or Foraminotomy) Any Method Under Indirect Image Guidance (Eg Fluoroscopic Ct) Single Or Multiple Levels Unilateral Or Bilateral: Lumbar	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
0276U	Hematology (Inherited Thrombocytopenia) Genomic Sequence Analysis Of 42 Genes Blood Buccal Swab Or Amniotic Fluid	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-

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0277U	Hematology (Genetic Platelet Function Disorder) Genomic Sequence Analysis Of 40 Genes And Duplication/Deletion Of Plau Blood Buccal Swab Or Amniotic Fluid	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	-	-
0278T	Transcutaneous Electrical Modulation Pain Reprocessing (Eg Scrambler Therapy) Each Treatment Session (Includes Placement Of Electrodes)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
0278U	Hematology (Genetic Thrombosis) Genomic Sequence Analysis Of 14 Genes Blood Buccal Swab Or Amniotic Fluid	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	_
0285U	Oncology Response To Radiation Cell-Free Dna Quantitative Branched Chain Dna Amplification Plasma Reported As A Radiation Toxicity Score	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
0286U	Cep72 (Centrosomal Protein 72-Kda) Nudt15 (Nudix Hydrolase 15) And Tpmt (Thiopurine S-Methyltransferase) (Eg Drug Metabolism) Gene Analysis Common Variants	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
0287U	Oncology (Thyroid) Dna And Mrna Next-Generation Sequencing Analysis Of 112 Genes Fine Needle Aspirate Or Formalin-Fixed Paraffin-Embedded (Ffpe) Tissue Algorithmic Prediction Of Cancer Recurrence Reported As A Categorical Risk Result (Low Intermediate High)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
0288U	Oncology (Lung) Mrna Quantitative Pcr Analysis Of 11 Genes (Bag1 Brca1 Cdc6 Cdk2Ap1 Erbb3 Fut3 Il11 Lck Rnd3 Sh3Bgr Wnt3A) And 3 Reference Genes (Esd Tbp Yap1) Formalin-Fixed Paraffin-Embedded (Ffpe) Tumor Tissue Algorithmic Interpretation Reported As A Recurrence Risk Score	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	_
0289U	Neurology (Alzheimer Disease) Mrna Gene Expression Profiling By Rna Sequencing Of 24 Genes Whole Blood Algorithm Reported As Predictive Risk Score	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
0290U	Pain Management Mrna Gene Expression Profiling By Rna Sequencing Of 36 Genes Whole Blood Algorithm Reported As Predictive Risk Score	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
0291U	Psychiatry (Mood Disorders) Mrna Gene Expression Profiling By Rna Sequencing Of 144 Genes Whole Blood Algorithm Reported As Predictive Risk Score	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	-	-
0292U	Psychiatry (Stress Disorders) Mrna Gene Expression Profiling By Rna Sequencing Of 72 Genes Whole Blood Algorithm Reported As Predictive Risk Score	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
0293U	Psychiatry (Suicidal Ideation) Mrna Gene Expression Profiling By Rna Sequencing Of 54 Genes Whole Blood Algorithm Reported As Predictive Risk Score	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
0294U	Longevity And Mortality Risk Mrna Gene Expression Profiling By Rna Sequencing Of 18 Genes Whole Blood Algorithm Reported As Predictive Risk Score	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-

0296U	Oncology (Oral And/Or Oropharyngeal Cancer) Gene Expression Profiling By Rna Sequencing At Least 20 Molecular Features (Eg Human And/Or Microbial Mrna) Saliva Algorithm Reported As Positive Or Negative For Signature Associated With Malignancy	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	_
0297U	Oncology (Pan Tumor) Whole Genome Sequencing Of Paired Malignant And Normal Dna Specimens Fresh Or Formalin-Fixed Paraffin-Embedded (Ffpe) Tissue Blood Or Bone Marrow Comparative Sequence Analyses And Variant Identification	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
0298U	Oncology (Pan Tumor) Whole Transcriptome Sequencing Of Paired Malignant And Normal Rna Specimens Fresh Or Formalin-Fixed Paraffin-Embedded (Ffpe) Tissue Blood Or Bone Marrow Comparative Sequence Analyses And Expression Level And Chimeric Transcript Identification	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
0299U	Oncology (Pan Tumor) Whole Genome Optical Genome Mapping Of Paired Malignant And Normal Dna Specimens Fresh Frozen Tissue Blood Or Bone Marrow Comparative Structural Variant Identification	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
0300U	Oncology (Pan Tumor) Whole Genome Sequencing And Optical Genome Mapping Of Paired Malignant And Normal Dna Specimens Fresh Tissue Blood Or Bone Marrow Comparative Sequence Analyses And Variant Identification	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	_
0306U	Oncology (Minimal Residual Disease [Mrd]) Next- Generation Targeted Sequencing Analysis Cell-Free Dna Initial (Baseline) Assessment To Determine A Patient Specific Panel For Future Comparisons To Evaluate For Mrd	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
0307U	Oncology (Minimal Residual Disease [Mrd]) Next- Generation Targeted Sequencing Analysis Of A Patient- Specific Panel Cell-Free Dna Subsequent Assessment With Comparison To Previously Analyzed Patient Specimens To Evaluate For Mrd	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	_
0308T	Insertion Of Ocular Telescope Prosthesis Including Removal Of Crystalline Lens Or Intraocular Lens Prosthesis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	-	Add effective 02/15/2024
0313U	Oncology (Pancreas) Dna And Mrna Next-Generation Sequencing Analysis Of 74 Genes And Analysis Of Cea (Ceacam5) Gene Expression Pancreatic Cyst Fluid Algorithm Reported As A Categorical Result (Ie Negative Low Probability Of Neoplasia Or Positive High Probability Of Neoplasia)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-

	Oncology (Cutaneous Melanoma) Mrna Gene Expression	I			
	Profiling By Rt-Pcr Of 35 Genes (32 Content And 3	MP Criteria: Procedures/services reviewed against Medical			
0314U	Housekeeping) Utilizing Formalin-Fixed Paraffin-Embedded	Policy Criteria. Submit for Recommended Clinical Review to			
03140	. 5.	,	_	-	_
	(Ffpe) Tissue Algorithm Reported As A Categorical Result (Ie	avoid post-service review by Careion.			
	Benign Intermediate Malignant) Oncology (Cutaneous Squamous Cell Carcinoma) Mrna				
		MP Criteria: Procedures/services reviewed against Medical			
0315U	. , , , , ,	Policy Criteria. Submit for Recommended Clinical Review to			
03130	And 6 Housekeeping) Utilizing Formalin-Fixed Paraffin-	•	_	_	_
	Embedded (Ffpe) Tissue Algorithm Reported As A	avoid post-service review by Carelon.			
	Categorical Risk Result (le Class 1 Class 2A Class 2B)				
	Oncology (Lung Cancer) Four-Probe Fish (3Q29 3P22.1	MP Criteria: Procedures/services reviewed against Medical			
0317U	10Q22.3 10Cen) Assay Whole Blood Predictive	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Algorithmgenerated Evaluation Reported As Decreased Or	avoid post-service review by Carelon.			
	Increased Risk For Lung Cancer	MD Critoria, Dragoduros (corrigos reviewed against Madical			
0318U	Pediatrics (Congenital Epigenetic Disorders) Whole Genome	_			
	Methylation Analysis By Microarray For 50 Or More Genes	Policy Criteria. Submit for Recommended Clinical Review to	-	-	
	Blood	avoid post-service review by Carelon.			
	Nephrology (Renal Transplant) Rna Expression By Select	MP Criteria: Procedures/services reviewed against Medical			
0319U	Transcriptome Sequencing Using Pretransplant Peripheral	Policy Criteria. Submit for Recommended Clinical Review to			
	Blood Algorithm Reported As A Risk Score For Early Acute	avoid post-service review by Carelon.			
	Rejection	<u>'</u>			
	Nephrology (Renal Transplant) Rna Expression By Select	MP Criteria: Procedures/services reviewed against Medical			
0320U	Transcriptome Sequencing Using Posttransplant Peripheral	Policy Criteria. Submit for Recommended Clinical Review to			
	Blood Algorithm Reported As A Risk Score For Acute Cellular	ar avoid post-service review by Carelon.	_	_	_
	Rejection	<u>'</u>			
	Neurology (Autism Spectrum Disorder [Asd]) Quantitative				
	Measurements Of 14 Acyl Carnitines And Microbiome-	MP Criteria: Procedure/service reviewed against Medical			
0322U	Derived Metabolites Liquid Chromatography With Tandem	Policy Criteria. Submit for Recommended Clinical Review to			
	Mass Spectrometry (Lc-Ms/Ms) Plasma Results Reported As	avoid post-service review.	_		
	Negative Or Positive For Risk Of Metabolic Subtypes				Add effective 10/15/2023
	Associated With Asd			1/14/2024	Retire effective 02/01/2024
	Neurology (Autism Spectrum Disorder [Asd]) Quantitative				
	Measurements Of 14 Acyl Carnitines And Microbiome-	EIU: Procedure/service not reimbursed by the Plan. Not			
0322U	Derived Metabolites Liquid Chromatography With Tandem	subject to pre-service review. Check EIU policy, which is			
	Mass Spectrometry (Lc-Ms/Ms) Plasma Results Reported As	one of our Clinical Payment and Coding Policy (CPCP).		_	
	Negative Or Positive For Risk Of Metabolic Subtypes	one of our diminum ayment and doding toney (or or).			
	Associated With Asd		1/15/2024		Add effective 02/01/2024
	Targeted Genomic Sequence Analysis Panel Solid Organ				
0326U	Neoplasm Cell-Free Circulating Dna Analysis Of 83 Or More	MP Criteria: Procedures/services reviewed against Medical			
	Genes Interrogation For Sequence Variants Gene Copy	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Number Amplifications Gene Rearrangements	avoid post-service review by Carelon.			
	Microsatellite Instability And Tumor Mutational Burden				
	Fetal Aneuploidy (Trisomy 13 18 And 21) Dna Sequence	MP Criteria: Procedures/services reviewed against Medical			
0327U	Analysis Of Selected Regions Using Maternal Plasma	Policy Criteria. Submit for Recommended Clinical Review to			
032.0	Algorithm Reported As A Risk Score For Each Trisomy	avoid post-service review by Carelon.	-	-	_
	Includes Sex Reporting If Performed	avoid post service review by earcion.			

0329U	Oncology (Neoplasia) Exome And Transcriptome Sequence Analysis For Sequence Variants Gene Copy Number Amplifications And Deletions Gene Rearrangements Microsatellite Instability And Tumor Mutational Burden Utilizing Dna And Rna From Tumor With Dna From Normal Blood Or Saliva For Subtraction Report Of Clinically Significant Mutation(S) With Therapy Associations	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	_	_
0330Т	Tear Film Imaging Unilateral Or Bilateral With Interpretation And Report	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0331T	Myocardial Sympathetic Innervation Imaging Planar Qualitative And Quantitative Assessment;	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	-	-
0331U	Oncology (Hematolymphoid Neoplasia) Optical Genome Mapping For Copy Number Alterations And Gene Rearrangements Utilizing Dna From Blood Or Bone Marrow Report Of Clinically Significant Alternations	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	_
0332Т	Myocardial Sympathetic Innervation Imaging Planar Qualitative And Quantitative Assessment; With Tomographic Spect	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	-	-	-
0332U	Oncology (Pan-Tumor) Genetic Profiling Of 8 Dna- Regulatory (Epigenetic) Markers By Quantitative Polymerase Chain Reaction (Qpcr) Whole Blood Reported As A High Or Low Probability Of Responding To Immune Checkpoint—Inhibitor Therapy	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
0333U	Oncology (Liver) Surveillance For Hepatocellular Carcinoma (Hcc) In Highrisk Patients Analysis Of Methylation Patterns On Circulating Cell-Free Dna (Cfdna) Plus Measurement Of Serum Of Afp/Afp-L3 And Oncoprotein Des-Gammacarboxy-Prothrombin (Dcp) Algorithm Reported As Normal Or Abnormal Result	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	_
0334U	Oncology (Solid Organ) Targeted Genomic Sequence Analysis Formalin-Fixed Paraffinembedded (Ffpe) Tumor Tissue Dna Analysis 84 Or More Genes Interrogation For Sequence Variants Gene Copy Number Amplifications Gene Rearrangements Microsatellite Instability And Tumor Mutational Burden	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
0335T	Insertion Of Sinus Tarsi Implant	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	-

0335U	Rare Diseases (Constitutional/Heritable Disorders) Whole Genome Sequence Analysis Including Small Sequence Changes Copy Number Variants Deletions Duplications Mobile Element Insertions Uniparental Disomy (Upd) Inversions Aneuploidy Mitochondrial Genome Sequence Analysis With Heteroplasmy And Large Deletions Short Tandem Repeat (Str) Gene Expansions Fetal Sample Identification And Categorization Of Genetic Variants	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_	-
0336U	Rare Diseases (Constitutional/Heritable Disorders) Whole Genome Sequence Analysis Including Small Sequence Changes Copy Number Variants Deletions Duplications Mobile Element Insertions Uniparental Disomy (Upd) Inversions Aneuploidy Mitochondrial Genome Sequence Analysis With Heteroplasmy And Large Deletions Short Tandem Repeat (Str) Gene Expansions Blood Or Saliva Identification And Categorization Of Genetic Variants Each Comparator Genome (Eg. Parent)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
0338Т	Transcatheter Renal Sympathetic Denervation Percutaneous Approach Including Arterial Puncture Selective Catheter Placement(S) Renal Artery(les) Fluoroscopy Contrast Injection(S) Intraprocedural Roadmapping And Radiological Supervision And Interpretation Including Pressure Gradient Measurements Flush Aortogram And Diagnostic Renal Angiography When Performed: Unilateral	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	-	-
0339Т	Transcatheter Renal Sympathetic Denervation Percutaneous Approach Including Arterial Puncture Selective Catheter Placement(S) Renal Artery(les) Fluoroscopy Contrast Injection(S) Intraprocedural Roadmapping And Radiological Supervision And Interpretation Including Pressure Gradient Measurements Flush Aortogram And Diagnostic Renal Angiography When Performed: Bilateral	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
0339U	Oncology (Prostate) Mrna Expression Profiling Of Hoxc6 And Dlx1 Reverse Transcription Polymerase Chain Reaction (Rt-Pcr) First-Void Urine Following Digital Rectal Examination Algorithm Reported As Probability Of High- Grade Cancer	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
0340U	Oncology (Pan-Cancer) Analysis Of Minimal Residual Disease (Mrd) From Plasma With Assays Personalized To Each Patient Based On Prior Next-Generation Sequencing Of The Patient'S Tumor And Germline Dna Reported As Absence Or Presence Of Mrd With Disease-Burden Correlation If Appropriate	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	_	-

0341U	Fetal Aneuploidy Dna Sequencing Comparative Analysis Fetal Dna From Products Of Conception Reported As Normal (Euploidy) Monosomy Trisomy Or Partial Deletion/Duplication Mosaicism And Segmental Aneuploid	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
0343U	Oncology (Prostate) Exosome-Based Analysis Of 442 Small Noncoding Rnas (Sncrnas) By Quantitative Reverse Transcription Polymerase Chain Reaction (Rt-Qpcr) Urine Reported As Molecular Evidence Of No- Low- Intermediate- Or High-Risk Of Prostate Cancer	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
0345T	Transcatheter Mitral Valve Repair Percutaneous Approach Via The Coronary Sinus	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	-	-	-
0345U	Psychiatry (Eg Depression Anxiety Attention Deficit Hyperactivity Disorder [Adhd]) Genomic Analysis Panel Variant Analysis Of 15 Genes Including Deletion/Duplication Analysis Of Cyp2D6	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
0347T	Placement Of Interstitial Device(S) In Bone For Radiostereometric Analysis (Rsa)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
0347U	Drug Metabolism Or Processing (Multiple Conditions) Whole Blood Or Buccal Specimen Dna Analysis 16 Gene Report With Variant Analysis And Reported Phenotypes	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
0348T	Radiologic Examination Radiostereometric Analysis (Rsa); Spine (Includes Cervical Thoracic And Lumbosacral When Performed)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
0348U	Drug Metabolism Or Processing (Multiple Conditions) Whole Blood Or Buccal Specimen Dna Analysis 25 Gene Report With Variant Analysis And Reported Phenotypes	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
0349T	Radiologic Examination Radiostereometric Analysis (Rsa); Upper Extremity(les) (Includes Shoulder Elbow And Wrist When Performed)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
0349U	Drug Metabolism Or Processing (Multiple Conditions) Whole Blood Or Buccal Specimen Dna Analysis 27 Gene Report With Variant Analysis Including Reported Phenotypes And Impacted Gene-Drug Interactions	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	_	-	-
0350Т	Radiologic Examination Radiostereometric Analysis (Rsa); Lower Extremity(les) (Includes Hip Proximal Femur Knee And Ankle When Performed)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
0350U	Drug Metabolism Or Processing (Multiple Conditions) Whole Blood Or Buccal Specimen Dna Analysis 27 Gene Report With Variant Analysis And Reported Phenotypes	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
0352Т	Optical Coherence Tomography Of Breast Or Axillary Lymph Node Excised Tissue Each Specimen; Interpretation And Report Real-Time Or Referred	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	-	-

	Optical Coherence Tomography Of Breast Surgical Cavity;	MP Criteria: Procedure/service reviewed against Medical			
0354T	Interpretation And Report Real-Time Or Referred	Policy Criteria. Submit for Recommended Clinical Review to	_		
		avoid post-service review.			
	Apol1 (Apolipoprotein L1) (Eg Chronic Kidney Disease) Risk	MP Criteria: Procedures/services reviewed against Medical			
0355U	Variants (G1 G2)	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by Carelon.			
	Oncology (Oropharyngeal Or Anal) Evaluation Of 17 Dna	MP Criteria: Procedures/services reviewed against Medical			
0356U	Biomarkers Using Droplet Digital Pcr (Ddpcr) Cell-Free Dna	Policy Criteria. Submit for Recommended Clinical Review to			
	Algorithm Reported As A Prognostic Risk Score For Cancer	avoid post-service review by Carelon.	_	_	_
	Recurrence	· ·			
02507	Bioelectrical Impedance Analysis Whole Body Composition	EIU: Procedure/service not reimbursed by the Plan. Not			
0358T	Assessment With Interpretation And Report	subject to pre-service review. Check EIU policy, which is	-	_	-
	Once le su (Parrille su Thurseid Courses) Course Françaises	one of our Clinical Payment and Coding Policy (CPCP).			
	Oncology (Papillary Thyroid Cancer) Gene-Expression Profiling Via Targeted Hybrid Capture—Enrichment Rna				
	Sequencing Of 82 Content Genes And 10 Housekeeping	MP Criteria: Procedures/services reviewed against Medical			
0362U	Genes Fine Needle Aspirate Or Formalin-Fixed	Policy Criteria. Submit for Recommended Clinical Review to _	_	_	_
	Paraffinembedded (Ffpe) Tissue Algorithm Reported As One	avoid post-service review by Carelon.			
	Of Three Molecular Subtypes				
	Oncology (Urothelial) Mrna Gene-Expression Profiling By				
	Real-Time Quantitative Pcr Of 5 Genes (Mdk Hoxa13 Cdc2	MD Critoria, Procedures (somious reviewed against Madie)			
00.0011	[Cdk1] Igfbp5 And Cxcr2) Utilizing Urine Algorithm	MP Criteria: Procedures/services reviewed against Medical			
0363U	Incorporates Age Sex Smoking History And	Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	_	-
	Macrohematuria Frequency Reported As A Risk Score For				
	Having Urothelial Carcinoma				
	Oncology (Hematolymphoid Neoplasm) Genomic Sequence				
	Analysis Using Multiplex (Pcr) And Next-Generation	MP Criteria: Procedures/services reviewed against Medical			
0364U	Sequencing With Algorithm Quantification Of Dominant	Policy Criteria. Submit for Recommended Clinical Review to	1/1/2024		
03010	Clonal Sequence(S) Reported As Presence Or Absence Of	avoid post-service review by Carelon.	1, 1, 202 1	-	Moved from PA to
	Minimal Residual Disease (Mrd) With Quantitation Of	arola post ser nee rement sy earelenn			Recommended Clinical Review
	Disease Burden When Appropriate				01/01/2024
	Oncology (Colorectal Cancer) Evaluation For Mutations Of				
	Apc Braf Ctnnb1 Kras Nras Pik3Ca Smad4 And Tp53 And	NAD Critaria: Praeaduras (carrigas ravious dagainst Madical			
036011	Methylation Markers (Myo1G Kcnq5 C9Orf50 Fli1 Clip4	MP Criteria: Procedures/services reviewed against Medical	1 /1 /2024		
0368U	Znf132 And Twist1) Multiplex Quantitative Polymerase	Policy Criteria. Submit for Recommended Clinical Review to	1/1/2024	_	Moved from PA to
	Chain Reaction (Qpcr) Circulating Cell-Free Dna (Cfdna)	avoid post-service review by Carelon.			Recommended Clinical Review
	Plasma Report Of Risk Score For Advanced Adenoma Or				01/01/2024
	Colorectal Cancer Infectious Agent Detection By Nucleic Acid (Dna And Rna)			 	01/01/2024
	Gastrointestinal Pathogens 31 Bacterial Viral And Parasitic	MP Criteria: Procedure/service reviewed against Medical			
0369U	Organisms And Identification Of 21 Associated Antibiotic-	Policy Criteria. Submit for Recommended Clinical Review to			
03030	Resistance Genes Multiplex Amplified Probe Technique	avoid post-service review.			Add effective 02/01/2024
	Nesistance denes Multiplex Amplinea Frobe Technique	· ·	2/1/2024	5/14/2024	Retire effective 05/14/2024

0369U	Infectious Agent Detection By Nucleic Acid (Dna And Rna) Gastrointestinal Pathogens 31 Bacterial Viral And Parasitic Organisms And Identification Of 21 Associated Antibiotic- Resistance Genes Multiplex Amplified Probe Technique	EIU: Procedure/service not 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	-	Add effective 05/015/2024
0378Т	Visual Field Assessment With Concurrent Real Time Data Analysis And Accessible Data Storage With Patient Initiated Data Transmitted To A Remote Surveillance Center For Up To 30 Days; Review And Interpretation With Report By A Physician Or Other Qualified Health Care Professional	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
0378U	Rfc1 (Replication Factor C Subunit 1) Repeat Expansion Variant Analysis By Traditional And Repeat-Primed Pcr Blood Saliva Or Buccal Swab	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	1/1/2024	-	Moved from PA to Recommended Clinical Review 01/01/2024
0379Т	Visual Field Assessment With Concurrent Real Time Data Analysis And Accessible Data Storage With Patient Initiated Data Transmitted To A Remote Surveillance Center For Up To 30 Days; Technical Support And Patient Instructions Surveillance Analysis And Transmission Of Daily And Emergent Data Reports As Prescribed By A Physician Or Other Qualified Health Care Professional	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
0379U	Targeted Genomic Sequence Analysis Panel Solid Organ Neoplasm Dna (523 Genes) And Rna (55 Genes) By Nextgeneration Sequencing Interrogation For Sequence Variants Gene Copy Number Amplifications Gene Rearrangements Microsatellite Instability And Tumor Mutational Burden	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	1/1/2024	-	Moved from PA to Recommended Clinical Review 01/01/2024
0380U	Drug Metabolism (Adverse Drug Reactions And Drug Response) Targeted Sequence Analysis 20 Gene Variants And Cyp2D6 Deletion Or Duplication Analysis With Reported Genotype And Phenotype	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	1/1/2024	-	Moved from PA to Recommended Clinical Review 01/01/2024
0388U	Oncology (Non-Small Cell Lung Cancer) Next-Generation Sequencing With Identification Of Single Nucleotide Variants Copy Number Variants Insertions And Deletions And Structural Variants In 37 Cancer-Related Genes Plasma With Report For Alteration Detection	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS.	-	-	-
0389U	Pediatric Febrile Illness (Kawasaki Disease [Kd]) Interferon Alphainducible Protein 27 (Ifi27) And Mast Cell-Expressed Membrane Protein 1 (Mcemp1) Rna Using Reverse Transcription Polymerase Chain Reaction (Rt-Qpcr) Blood Reported As A Risk Score For Kd	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS.	-	-	-

0391U	Oncology (Solid Tumor) Dna And Rna By Next-Generation Sequencing Utilizing Formalin-Fixed Paraffin-Embedded (Ffpe) Tissue 437 Genes Interpretive Report For Single Nucleotide Variants Splicesite Variants Insertions/Deletions Copy Number Alterations Gene Fusions Tumor Mutational Burden And Microsatellite Instability With Algorithm Quantifying Immunotherapy Response Score	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS.	_	_	_
0392U	Drug Metabolism (Depression Anxiety Attention Deficit Hyperactivity Disorder [Adhd]) Gene-Drug Interactions Variant Analysis Of 16 Genes Including Deletion/Duplication Analysis Of Cyp2D6 Reported As Impact Of Gene-Drug Interaction For Each Drug	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS.	-	-	_
0394T	High Dose Rate Electronic Brachytherapy Skin Surface Application Per Fraction Includes Basic Dosimetry When Performed	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
0395T	High Dose Rate Electronic Brachytherapy Interstitial Or Intracavitary Treatment Per Fraction Includes Basic Dosimetry When Performed	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	-	-	-
0396U	Obstetrics (Pre-Implantation Genetic Testing) Evaluation Of 300000 Dna Single-Nucleotide Polymorphisms (Snps) By Microarray Embryonic Tissue Algorithm Reported As A Probability For Single-Gene Germline Conditions	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS.	-	-	_
0397Т	Endoscopic Retrograde Cholangiopancreatography (Ercp) With Optical Endomicroscopy (List Separately In Addition To Code For Primary Procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
0398Т	Magnetic Resonance Image Guided High Intensity Focused Ultrasound (Mrgfus) Stereotactic Ablation Lesion Intracranial For Movement Disorder Including Stereotactic Navigation And Frame Placement When Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	-	_	-
0400U	Obstetrics (Expanded Carrier Screening) 145 Genes By Nextgeneration Sequencing Fragment Analysis And Multiplex Ligationdependent Probe Amplification Dna Reported As Carrier Positive Or Negative	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS.	-	-	-
0401U	Cardiology (Coronary Heart Disease [Cad]) 9 Genes (12 Variants) Targeted Variant Genotyping Blood Saliva Or Buccal Swab Algorithm Reported As A Genetic Risk Score For A Coronary Event	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS.	-	-	-
0408T	Insertion Or Replacement Of Permanent Cardiac Contractility Modulation System Including Contractility Evaluation When Performed And Programming Of Sensing And Therapeutic Parameters; Pulse Generator With Transvenous Electrodes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	-	Add effective 04/01/2024

	Insertion Or Replacement Of Permanent Cardiac				
	Contractility Modulation System Including Contractility	MP Criteria: Procedure/service reviewed against Medical			
0409T	Evaluation When Performed And Programming Of Sensing	Policy Criteria. Submit for Recommended Clinical Review to			
	And Therapeutic Parameters; Pulse Generator Only	avoid post-service review.		_	
	The merapeaner arameters, raise semerator orm,		4/1/2024		Add effective 04/01/2024
	Insertion Or Replacement Of Permanent Cardiac				
	Contractility Modulation System Including Contractility	MP Criteria: Procedure/service reviewed against Medical			
0410T	Evaluation When Performed And Programming Of Sensing	Policy Criteria. Submit for Recommended Clinical Review to			
	And Therapeutic Parameters; Atrial Electrode Only	avoid post-service review.			
	,	· ·	4/1/2024		Add effective 04/01/2024
	Insertion Or Replacement Of Permanent Cardiac				
	Contractility Modulation System Including Contractility	MP Criteria: Procedure/service reviewed against Medical			
0411T	Evaluation When Performed And Programming Of Sensing	Policy Criteria. Submit for Recommended Clinical Review to		_	
	And Therapeutic Parameters; Ventricular Electrode Only	avoid post-service review.			
			4/1/2024		Add effective 04/01/2024
	Removal Of Permanent Cardiac Contractility Modulation	MP Criteria: Procedure/service reviewed against Medical			
0412T	System; Pulse Generator Only	Policy Criteria. Submit for Recommended Clinical Review to		_	
		avoid post-service review.	4/1/2024		Add effective 04/01/2024
	Removal Of Permanent Cardiac Contractility Modulation	MP Criteria: Procedure/service reviewed against Medical			
0413T	System; Transvenous Electrode (Atrial Or Ventricular)	Policy Criteria. Submit for Recommended Clinical Review to		_	
		avoid post-service review.	4/1/2024		Add effective 04/01/2024
	Removal And Replacement Of Permanent Cardiac	MP Criteria: Procedure/service reviewed against Medical			
0414T	Contractility Modulation System Pulse Generator Only	Policy Criteria. Submit for Recommended Clinical Review to		_	
		avoid post-service review.	4/1/2024		Add effective 04/01/2024
	Repositioning Of Previously Implanted Cardiac Contractility	MP Criteria: Procedure/service reviewed against Medical			
0415T	Modulation Transvenous Electrode (Atrial Or Ventricular	Policy Criteria. Submit for Recommended Clinical Review to		_	
	Lead)	avoid post-service review.	4/1/2024		Add effective 04/01/2024
	Relocation Of Skin Pocket For Implanted Cardiac	MP Criteria: Procedure/service reviewed against Medical			
0416T	Contractility Modulation Pulse Generator	Policy Criteria. Submit for Recommended Clinical Review to	4/4/2024	_	A dd a ff a dd a 04 /04 /000 A
	2	avoid post-service review.	4/1/2024		Add effective 04/01/2024
	Programming Device Evaluation (In Person) With Iterative				
	Adjustment Of The Implantable Device To Test The Function	MP Criteria: Procedure/service reviewed against Medical			
0417T	Of The Device And Select Optimal Permanent Programmed	Policy Criteria. Submit for Recommended Clinical Review to		_	
	Values With Analysis Including Review And Report	avoid post-service review.			
	Implantable Cardiac Contractility Modulation System		4/1/2024		Add effective 04/01/2024
	Interrogation Device Evaluation (In Person) With Analysis		4/ 1/ 2024		Add effective 04/01/2024
	Review And Report Includes Connection Recording And	MP Criteria: Procedure/service reviewed against Medical			
0418T	·	Policy Criteria. Submit for Recommended Clinical Review to		_	
	Disconnection Per Patient Encounter Implantable Cardiac	avoid post-service review.	4/1/2024		Add effective 04/01/2024
	Contractility Modulation System Tactile Breast Imaging By Computer-Aided Tactile Sensors	MP Criteria: Procedure/service reviewed against Medical	7, 1, 2024		Add effective 04/01/2024
0422T	Unilateral Or Bilateral	Policy Criteria. Submit for Recommended Clinical Review to			
07221	Offinateral Of Bilateral	avoid post-service review.	-	-	-
	Ablation Percutaneous Cryoablation Includes	MP Criteria: Procedure/service reviewed against			
0440T	Imaging Guidance; Upper Extremity Distal/Peripheral	Medical Policy Criteria. Submit for Recommended			
04401		•	5/1/2024	-	Add effective 05/01/2024
	Nerve	Clinical Review to avoid post-service review.	J/ 1/ 2024		Add effective 05/01/2024

	Ablation Percutaneous Cryoablation Includes	MP Criteria: Procedure/service reviewed against			
0441T	Imaging Guidance; Lower Extremity Distal/Peripheral	Medical Policy Criteria. Submit for Recommended			
	Nerve	Clinical Review to avoid post-service review.	5/1/2024	_	Add effective 05/01/2024
	Ablation Percutaneous Cryoablation Includes	MP Criteria: Procedure/service reviewed against			
0442T	Imaging Guidance; Nerve Plexus Or Other Truncal	Medical Policy Criteria. Submit for Recommended			
	Nerve (Eg Brachial Plexus Pudendal Nerve)	Clinical Review to avoid post-service review.	5/1/2024		Add effective 05/01/2024
	Insertion Of Aqueous Drainage Device Without Extraocular	MP Criteria: Procedure/service reviewed against Medical			
0449T	Reservoir Internal Approach Into The Subconjunctival	Policy Criteria. Submit for Recommended Clinical Review to			
	Space; Initial Device	avoid post-service review.			
	Insertion Of Aqueous Drainage Device Without Extraocular	MP Criteria: Procedure/service reviewed against Medical			
0450T	Reservoir Internal Approach Into The Subconjunctival	Policy Criteria. Submit for Recommended Clinical Review to			
04301	Space; Each Additional Device (List Separately In Addition To	avoid post-service review.	-	-	-
	Code For Primary Procedure)	· ·			
0.4647	Visual Evoked Potential Testing For Glaucoma With	EIU: Procedure/service not reimbursed by the Plan. Not			
0464T	Interpretation And Report	subject to pre-service review. Check EIU policy, which is	-	-	-
	Device Evaluation Interrogation And Initial Programming Of	one of our Clinical Payment and Coding Policy (CPCP).			
	Intraocular Retinal Electrode Array (Eg. Retinal Prosthesis)				
	In Person With Iterative Adjustment Of The Implantable	EIU: Procedure/service not reimbursed by the Plan. Not			
0472T	Device To Test Functionality Select Optimal Permanent	subject to pre-service review. Check EIU policy, which is			
			_		-
	With Review And Report By A Qualified Health Care	, , , ,			
	Professional				
	Device Evaluation And Interrogation Of Intraocular Retinal				
	Electrode Array (Eg Retinal Prosthesis) In Person Including	EIU: Procedure/service not reimbursed by the Plan. Not			
0473T	Reprogramming And Visual Training When Performed With	subject to pre-service review. Check EIU policy, which is	_	_	_
	Review And Report By A Qualified Health Care Professional	one of our Clinical Payment and Coding Policy (CPCP).			
	Insertion Of Anterior Segment Aqueous Drainage Device	MP Criteria: Procedure/service reviewed against Medical			
0474T	With Creation Of Intraocular Reservoir Internal Approach	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Into The Supraciliary Space	avoid post-service review.			
	Fractional Ablative Laser Fenestration Of Burn And	MP Criteria: Procedure/service reviewed against Medical			
0479T	Traumatic Scars For Functional Improvement; First 100 Cm2	Policy Criteria. Submit for Recommended Clinical Review to			
	Or Part Thereof Or 1% Of Body Surface Area Of Infants And	avoid post-service review.	_		_
	Children	·			
	Fractional Ablative Laser Fenestration Of Burn And				
	Traumatic Scars For Functional Improvement; Each Additional 100 Cm2 Or Each Additional 1% Of Body Surface	MP Criteria: Procedure/service reviewed against Medical			
0480T	Area Of Infants And Children Or Part Thereof (List	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Separately In Addition To Code For Primary Procedure)	avoid post-service review.			
	Separately in Addition to Code For Filmary Procedure)				
	Transcatheter Mitral Valve Implantation/Replacement	MP Criteria: Procedure/service reviewed against Medical			
0483T	(Tmvi) With Prosthetic Valve; Percutaneous Approach	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Including Transseptal Puncture When Performed	avoid post-service review.			
	Transcatheter Mitral Valve Implantation/Replacement	MP Criteria: Procedure/service reviewed against Medical			
0484T	(Tmvi) With Prosthetic Valve; Transthoracic Exposure (Eg	Policy Criteria. Submit for Recommended Clinical Review to	_	_	-
	Thoracotomy Transapical)	avoid post-service review.			

	Optical Coherence Tomography (Oct) Of Middle Ear With	EIU: Procedure/service not reimbursed by the Plan. Not			
0485T	Interpretation And Report; Unilateral	subject to pre-service review. Check EIU policy, which is			
04031	interpretation And Report, Offilateral	one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
	Optical Coherence Tomography (Oct) Of Middle Ear With	EIU: Procedure/service not reimbursed by the Plan. Not			
0486T	Interpretation And Report; Bilateral	subject to pre-service review. Check EIU policy, which is			
04001	interpretation And Report, Bilateral	one of our Clinical Payment and Coding Policy (CPCP).	_	-	-
	Surgical Preparation And Cannulation Of Marginal	one of our chinical rayment and county foncy (crcr).			
	(Extended) Cadaver Donor Lung(S) To Ex Vivo Organ	MP Criteria: Procedure/service reviewed against Medical			
0494T	Perfusion System Including Decannulation Separation From	Policy Criteria. Submit for Recommended Clinical Review to			
04541		avoid post-service review.		-	
	The Perfusion System And Cold Preservation Of The	avoid post-service review.	2/1/2024		Add effective 02/01/2024
	Allograft Prior To Implantation When Performed Initiation And Monitoring Marginal (Extended) Cadaver		2/1/2024		Add effective 02/01/2024
	5 5 ,				
	Donor Lung(S) Organ Perfusion System By Physician Or				
	Qualified Health Care Professional Including Physiological	MP Criteria: Procedure/service reviewed against Medical			
0495T	And Laboratory Assessment (Eg Pulmonary Artery Flow	Policy Criteria. Submit for Recommended Clinical Review to			
04931	Pulmonary Artery Pressure Left Atrial Pressure Pulmonary			-	
	Vascular Resistance Mean/Peak And Plateau Airway	avoid post-service review.			
	Pressure Dynamic Compliance And Perfusate Gas Analysis)				
	Including Bronchoscopy And X Ray When Performed; First		2/1/2024		Add effective 02/01/2024
	Two Hours In Sterile Field Initiation And Monitoring Marginal (Extended) Cadaver		2/1/2024		Add effective 02/01/2024
	5 5 ,				
	Donor Lung(S) Organ Perfusion System By Physician Or				
	Qualified Health Care Professional Including Physiological				
	And Laboratory Assessment (Eg Pulmonary Artery Flow	MP Criteria: Procedure/service reviewed against Medical			
0496T	Pulmonary Artery Pressure Left Atrial Pressure Pulmonary	Policy Criteria. Submit for Recommended Clinical Review to		_	
	Vascular Resistance Mean/Peak And Plateau Airway	avoid post-service review.			
	Pressure Dynamic Compliance And Perfusate Gas Analysis)				
	Including Bronchoscopy And X Ray When Performed; Each				
	Additional Hour (List Separately In Addition To Code For		2/1/2024		Add effective 02/01/2024
	Primary Procedure	EIU: Procedure/service not reimbursed by the Plan. Not	2/1/2024		Add effective 02/01/2024
0507T	Near Infrared Dual Imaging (Ie Simultaneous Reflective And	subject to pre-service review. Check EIU policy, which is			
05071	Transilluminated Light) Of Meibomian Glands Unilateral Or		_	-	-
	Bilateral With Interpretation And Report Electroretinography (Erg) With Interpretation And Report	one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not			
0509T		subject to pre-service review. Check EIU policy, which is			
03031	Pattern (Perg)	one of our Clinical Payment and Coding Policy (CPCP).	-	-	_
	Removal And Reinsertion Of Sinus Tarsi Implant	EIU: Procedure/service not reimbursed by the Plan. Not			
0511T	Removal And Remisertion of Sinds Farsi implant	subject to pre-service review. Check EIU policy, which is			
03111		one of our Clinical Payment and Coding Policy (CPCP).	-	-	_
	Extracorporeal Shock Wave For Integumentary Wound	EIU: Procedure/service not reimbursed by the Plan. Not			
0512T	Healing Including Topical Application And Dressing Care;	subject to pre-service review. Check EIU policy, which is			
03121		one of our Clinical Payment and Coding Policy (CPCP).	_	-	-
	Initial Wound Extracorporeal Shock Wave For Integumentary Wound	one of our chilical Payment and County Policy (CPCP).			
	,	EIU: Procedure/service not reimbursed by the Plan. Not			
0513T	Healing Including Topical Application And Dressing Care;	subject to pre-service review. Check EIU policy, which is	_	_	_
	Each Additional Wound (List Separately In Addition To Code	one of our Clinical Payment and Coding Policy (CPCP).			
	For Primary Procedure)				

0524T	Endovenous Catheter Directed Chemical Ablation With Balloon Isolation Of Incompetent Extremity Vein Open Or Percutaneous Including All Vascular Access Catheter Manipulation Diagnostic Imaging Imaging Guidance And Monitoring	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	-	-	-
0537T	Chimeric Antigen Receptor T-Cell (Car-T) Therapy; Harvesting Of Blood-Derived T Lymphocytes For Development Of Genetically Modified Autologous Car-T Cells Per Day	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	-	_	-
0538T	Chimeric Antigen Receptor T-Cell (Car-T) Therapy; Preparation Of Blood-Derived T Lymphocytes For Transportation (Eg Cryopreservation Storage)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	-	_	-
0539Т	Chimeric Antigen Receptor T-Cell (Car-T) Therapy; Receipt And Preparation Of Car-T Cells For Administration	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	-	_	-
0540T	Chimeric Antigen Receptor T-Cell (Car-T) Therapy; Car-T Cell Administration Autologous	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	-	_	-
0544T	Transcatheter Mitral Valve Annulus Reconstruction With Implantation Of Adjustable Annulus Reconstruction Device Percutaneous Approach Including Transseptal Puncture	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	-	-	-
0545T	Transcatheter Tricuspid Valve Annulus Reconstruction With Implantation Of Adjustable Annulus Reconstruction Device Percutaneous Approach	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	-	-
0546T	Radiofrequency Spectroscopy Real Time Intraoperative Margin Assessment At The Time Of Partial Mastectomy With Report	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2024	-	Add effective 01/01/2024
0563T	Evacuation Of Meibomian Glands Using Heat Delivered Through Wearable Open-Eye Eyelid Treatment Devices And Manual Gland Expression Bilateral	one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
0565T	Autologous Cellular Implant Derived From Adipose Tissue For The Treatment Of Osteoarthritis Of The Knees; Tissue Harvesting And Cellular Implant Creation	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
0566T	Autologous Cellular Implant Derived From Adipose Tissue For The Treatment Of Osteoarthritis Of The Knees; Injection Of Cellular Implant Into Knee Joint Including Ultrasound Guidance Unilateral	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
0569T	Transcatheter Tricuspid Valve Repair Percutaneous Approach; Initial Prosthesis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	-	-
0570Т	Transcatheter Tricuspid Valve Repair Percutaneous Approach; Each Additional Prosthesis During Same Session (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	-	-	-

0584T	Islet Cell Transplant Includes Portal Vein Catheterization And Infusion Including All Imaging Including Guidance And Radiological Supervision And Interpretation When Performed; Percutaneous	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS.	-	-	Moved from PA to Recommended Clinical Review 9/18/2023
0585T	Islet Cell Transplant Includes Portal Vein Catheterization And Infusion Including All Imaging Including Guidance And Radiological Supervision And Interpretation When Performed; Laparoscopic	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS.	-	-	Moved from PA to Recommended Clinical Review 9/18/2023
0586T	Islet Cell Transplant Includes Portal Vein Catheterization And Infusion Including All Imaging Including Guidance And Radiological Supervision And Interpretation When Performed; Open	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS.	-	-	Moved from PA to Recommended Clinical Review 9/18/2023
0587Т	Percutaneous Implantation Or Replacement Of Integrated Single Device Neurostimulation System For Bladder Dysfunction Including Electrode Array And Receiver Or Pulse Generator Including Analysis Programming And Imaging Guidance When Performed Posterior Tibial Nerve	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	-	-	_
0588Т	Revision Or Removal Of Percutaneously Placed Integrated Single Device Neurostimulation System For Bladder Dysfunction Including Electrode Array And Receiver Or Pulse Generator Including Analysis Programming And Imaging Guidance When Performed Posterior Tibial Nerve	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	-	-	_
0589Т	Electronic Analysis With Simple Programming Of Implanted Integrated Neurostimulation System For Bladder Dysfunction (Eg Electrode Array And Receiver) Including Contact Group(S) Amplitude Pulse Width Frequency (Hz) On/Off Cycling Burst Dose Lockout Patient-Selectable Parameters Responsive Neurostimulation Detection Algorithms Closed-Loop Parameters And Passive Parameters When Performed By Physician Or Other Qualified Health Care Professional Posterior Tibial Nerve 1-3 Parameters	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	-	_	_
0590Т	Electronic Analysis With Complex Programming Of Implanted Integrated Neurostimulation System For Bladder Dysfunction (Eg Electrode Array And Receiver) Including Contact Group(S) Amplitude Pulse Width Frequency (Hz) On/Off Cycling Burst Dose Lockout Patient-Selectable Parameters Responsive Neurostimulation Detection Algorithms Closed-Loop Parameters And Passive Parameters When Performed By Physician Or Other Qualified Health Care Professional Posterior Tibial Nerve 4 Or More Parameters	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	-	_	_
0596Т	Temporary Female Intraurethral Valve-Pump (Ie Voiding Prosthesis); Initial Insertion Including Urethral Measurement	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	-	-	-

	Temporary Female Intraurethral Valve-Pump (le Voiding	MP Criteria: Procedure/service reviewed against Medical			
0597T	Prosthesis); Replacement	Policy Criteria. Submit for Recommended Clinical Review to			
03371	1 Tostilesis), replacement	avoid post-service review.	-	-	-
	Ablation Irreversible Electroporation; 1 Or More Tumors Per	· · ·			
0600T	Organ Including Imaging Guidance When Performed	Policy Criteria. Submit for Recommended Clinical Review to			
	Percutaneous	avoid post-service review.	-	_	-
	Ablation Irreversible Electroporation; 1 Or More Tumors Per				
0601T	Organ Including Fluoroscopic And Ultrasound Guidance	Policy Criteria. Submit for Recommended Clinical Review to			
0001.	When Performed Open	avoid post-service review.	-	_	-
	Glomerular Filtration Rate (Gfr) Measurement(S)				
	Transdermal Including Sensor Placement And	EIU: Procedure/service not reimbursed by the Plan. Not			
0602T	Administration Of A Single Dose Of Fluorescent Pyrazine	subject to pre-service review. Check EIU policy, which is	_	_	_
	Agent	one of our Clinical Payment and Coding Policy (CPCP).			
	Glomerular Filtration Rate (Gfr) Monitoring Transdermal				
	Including Sensor Placement And Administration Of More	EIU: Procedure/service not reimbursed by the Plan. Not			
0603T	Than One Dose Of Fluorescent Pyrazine Agent Each 24	subject to pre-service review. Check EIU policy, which is	_	_	_
	Hours	one of our Clinical Payment and Coding Policy (CPCP).			
	Eye-Movement Analysis Without Spatial Calibration With	EIU: Procedure/service not reimbursed by the Plan. Not			
0615T	Interpretation And Report	subject to pre-service review. Check EIU policy, which is			
		one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
	Cystourethroscopy With Transurethral Anterior Prostate	MP Criteria: Procedure/service reviewed against Medical			
0619T	Commissurotomy And Drug Delivery Including Transrectal	Policy Criteria. Submit for Recommended Clinical Review to			
	Ultrasound And Fluoroscopy When Performed	avoid post-service review.	3/15/2024	6/30/2024	Add effective 03/15/2024
	Cystourethroscopy With Transurethral Anterior Prostate	EIU: Procedure/service not reimbursed by the Plan. Not			
0619T	Commissurotomy And Drug Delivery Including Transrectal	subject to pre-service review. Check EIU policy, which is			
	Ultrasound And Fluoroscopy When Performed	one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024		Add effective 07/01/2024
	Endovascular Venous Arterialization Tibial Or Peroneal Vein				
	With Transcatheter Placement Of Intravascular Stent				
	Graft(S) And Closure By Any Method Including				
	Percutaneous Or Open Vascular Access Ultrasound	EIU: Procedure/service not reimbursed by the Plan. Not			
0620T	Guidance For Vascular Access When Performed All	subject to pre-service review. Check EIU policy, which is	_	_	_
	Catheterization(S) And Intraprocedural Roadmapping And	one of our Clinical Payment and Coding Policy (CPCP).			
	Imaging Guidance Necessary To Complete The Intervention				
	All Associated Radiological Supervision And Interpretation				
	When Performed				
	Trabeculostomy Ab Interno By Laser;	EIU: Procedure/service not reimbursed by the Plan. Not			
0621T		subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Trabeculostomy Ab Interno By Laser; With Use Of	EIU: Procedure/service not reimbursed by the Plan. Not			
0622T	Ophthalmic Endoscope	subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			

	Automated Quantification And Characterization Of Coronary				
	Atherosclerotic Plaque To Assess Severity Of Coronary				
	Disease Using Data From Coronary Computed Tomographic				
0623T	Angiography; Data Preparation And Transmission	subject to pre-service review. Check EIU policy, which is	_	_	_
	Computerized Analysis Of Data With Review Of	one of our Clinical Payment and Coding Policy (CPCP).			
	Computerized Analysis Output To Reconcile Discordant Data				
	Interpretation And Report				
	Automated Quantification And Characterization Of Coronary				
	Atherosclerotic Plaque To Assess Severity Of Coronary	EIU: Procedure/service not reimbursed by the Plan. Not			
0624T	Disease Using Data From Coronary Computed Tomographic	subject to pre-service review. Check EIU policy, which is	_	_	_
	Angiography; Data Preparation And Transmission	one of our Clinical Payment and Coding Policy (CPCP).			
	Automated Quantification And Characterization Of Coronary				
	Atherosclerotic Plaque To Assess Severity Of Coronary	EIU: Procedure/service not reimbursed by the Plan. Not			
0625T	Disease Using Data From Coronary Computed Tomographic		_	_	_
	Angiography; Computerized Analysis Of Data From Coronary	one of our Clinical Payment and Coding Policy (CPCP).			
	Computed Tomographic Angiography				
	Automated Quantification And Characterization Of Coronary				
	Atherosclerotic Plaque To Assess Severity Of Coronary	EIU: Procedure/service not reimbursed by the Plan. Not			
0626T	Disease Using Data From Coronary Computed Tomographic	subject to pre-service review. Check EIU policy, which is			
00201	Angiography; Review Of Computerized Analysis Output To	one of our Clinical Payment and Coding Policy (CPCP).	-	-	_
	Reconcile Discordant Data Interpretation And Report	one of our clinical rayment and coding roncy (cr cr).			
	Percutaneous Injection Of Allogeneic Cellular And/Or Tissue-	EIU: Procedure/service not reimbursed by the Plan. Not			
0627T	Based Product Intervertebral Disc Unilateral Or Bilateral	subject to pre-service review. Check EIU policy, which is			
00271	Injection With Fluoroscopic Guidance Lumbar; First Level	one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
	Percutaneous Injection Of Allogeneic Cellular And/Or Tissue-				
	Based Product Intervertebral Disc Unilateral Or Bilateral	EIU: Procedure/service not reimbursed by the Plan. Not			
0628T	Injection With Fluoroscopic Guidance Lumbar; Each	subject to pre-service review. Check EIU policy, which is	_	_	_
	Additional Level (List Separately In Addition To Code For	one of our Clinical Payment and Coding Policy (CPCP).			
	Primary Procedure)				
	Percutaneous Injection Of Allogeneic Cellular And/Or Tissue-				
0629T	Based Product Intervertebral Disc Unilateral Or Bilateral	subject to pre-service review. Check EIU policy, which is	_	_	_
	Injection With Ct Guidance Lumbar; First Level	one of our Clinical Payment and Coding Policy (CPCP).			
	Percutaneous Injection Of Allogeneic Cellular And/Or Tissue-				
	Based Product Intervertebral Disc Unilateral Or Bilateral	EIU: Procedure/service not reimbursed by the Plan. Not			
0630T	Injection With Ct Guidance Lumbar; Each Additional Level	subject to pre-service review. Check EIU policy, which is	-	_	-
	(List Separately In Addition To Code For Primary Procedure)	one of our Clinical Payment and Coding Policy (CPCP).			
	Transcutaneous Visible Light Hyperspectral Imaging	EIU: Procedure/service not reimbursed by the Plan. Not			
0631T	Measurement Of Oxyhemoglobin Deoxyhemoglobin And	subject to pre-service review. Check EIU policy, which is			
	Tissue Oxygenation With Interpretation And Report Per	one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
	Extremity	2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2			

	Percutaneous Transcatheter Ultrasound Ablation Of Nerves	MP Criteria: Procedure/service reviewed against Medical			
0632T	Innervating The Pulmonary Arteries Including Right Heart	Policy Criteria. Submit for Recommended Clinical Review to			
00321	Catheterization Pulmonary Artery Angiography And All	avoid post-service review.	_	_	-
	Imaging Guidance	'			
	Computed Tomography Breast Including 3D Rendering	MP Criteria: Procedures/services reviewed against Medical			
0633T	When Performed Unilateral; Without Contrast Material	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by BCBS.			
	Computed Tomography Breast Including 3D Rendering	MP Criteria: Procedures/services reviewed against Medical			
0634T	When Performed Unilateral; With Contrast Material(S)	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by BCBS.			
	Computed Tomography Breast Including 3D Rendering	MP Criteria: Procedures/services reviewed against Medical			
0635T	When Performed Unilateral; Without Contrast Followed By	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Contrast Material(S)	avoid post-service review by BCBS.			
	Computed Tomography Breast Including 3D Rendering	MP Criteria: Procedures/services reviewed against Medical			
0636T	When Performed Bilateral; Without Contrast Material(S)	Policy Criteria. Submit for Recommended Clinical Review to	_		_
		avoid post-service review by BCBS.			
	Computed Tomography Breast Including 3D Rendering	MP Criteria: Procedures/services reviewed against Medical			
0637T	When Performed Bilateral; With Contrast Material(S)	Policy Criteria. Submit for Recommended Clinical Review to	_	L	_
		avoid post-service review by BCBS.			
	Computed Tomography Breast Including 3D Rendering	MP Criteria: Procedures/services reviewed against Medical			
0638T	When Performed Bilateral; Without Contrast Followed By	Policy Criteria. Submit for Recommended Clinical Review to			
	Contrast Material(S)	avoid post-service review by BCBS.			
	Wireless Skin Sensor Thermal Anisotropy Measurement(S)	EIU: Procedure/service not reimbursed by the Plan. Not			
0639T	And Assessment Of Flow In Cerebrospinal Fluid Shunt	subject to pre-service review. Check EIU policy, which is			
	Including Ultrasound Guidance When Performed	one of our Clinical Payment and Coding Policy (CPCP).			
	Noncontact Near-Infrared Spectroscopy (Eg For	, , , ,			
	Measurement Of Deoxyhemoglobin Oxyhemoglobin And	EIU: Procedure/service not reimbursed by the Plan. Not			
0640T	Ratio Of Tissue Oxygenation) Other Than For Screening For	subject to pre-service review. Check EIU policy, which is			
	Peripheral Arterial Disease Image Acquisition Interpretation	t t	_	_	
	And Report; First Anatomic Site	, , , , , , , , , , , , , , , , , , , ,			
	Transcatheter Left Ventricular Restoration Device				
	Implantation Including Right And Left Heart Catheterization	MP Criteria: Procedure/service reviewed against Medical			
0643T	And Left Ventriculography When Performed Arterial	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Approach	avoid post-service review.			
	Transcatheter Implantation Of Coronary Sinus Reduction				
	Device Including Vascular Access And Closure Right Heart	MP Criteria: Procedure/service reviewed against Medical			
0645T	Catheterization Venous Angiography Coronary Sinus	Policy Criteria. Submit for Recommended Clinical Review to			
00.0.	Angiography Imaging Guidance And Supervision And	avoid post-service review.	_	_	_
	Interpretation When Performed	arous post service review.			
	Transcatheter Tricuspid Valve Implantation				
	(Ttvi)/Replacement With Prosthetic Valve Percutaneous	MP Criteria: Procedure/service reviewed against Medical			
0646T	Approach Including Right Heart Catheterization Temporary	Policy Criteria. Submit for Recommended Clinical Review to			
00.01	Pacemaker Insertion And Selective Right Ventricular Or	avoid post-service review.	-	-	-
	<u> </u>	avoid post-sei vice review.			
	Right Atrial Angiography When Performed			1	<u> </u>

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	Quantitative Magnetic Resonance For Analysis Of Tissue				
	Composition (Eg Fat Iron Water Content) Including				
	Multiparametric Data Acquisition Data Preparation And	MP Criteria: Procedures/services reviewed against Medical			
0648T	Transmission Interpretation And Report Obtained Without	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Diagnostic Mri Examination Of The Same Anatomy (Eg	avoid post-service review by BCBS.			
	Organ Gland Tissue Target Structure) During The Same				
	Session: Single Organ				
	Quantitative Magnetic Resonance For Analysis Of Tissue				
	Composition (Eg Fat Iron Water Content) Including				
	Multiparametric Data Acquisition Data Preparation And	MP Criteria: Procedures/services reviewed against Medical			
0649T	Transmission Interpretation And Report Obtained With	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Diagnostic Mri Examination Of The Same Anatomy (Eg	avoid post-service review by BCBS.			
	Organ Gland Tissue Target Structure); Single Organ (List				
	Separately In Addition To Code For Primary Procedure)				
	Programming Device Evaluation (Remote) Of Subcutaneous				
	Cardiac Rhythm Monitor System With Iterative Adjustment				
	Of The Implantable Device To Test The Function Of The	MP Criteria: Procedure/service reviewed against Medical			
0650T	Device And Select Optimal Permanently Programmed Values	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	With Analysis Review And Report By A Physician Or Other	avoid post-service review.			
	Qualified Health Care Professional				
	Magnetically Controlled Capsule Endoscopy Esophagus	EIU: Procedure/service not reimbursed by the Plan. Not			
0651T	Through Stomach Including Intraprocedural Positioning Of	subject to pre-service review. Check EIU policy, which is	_	_	_
	Capsule With Interpretation And Report	one of our Clinical Payment and Coding Policy (CPCP).			
	Anterior Lumbar Or Thoracolumbar Vertebral Body	EIU: Procedure/service not reimbursed by the Plan. Not			
0656T	Tethering; Up To 7 Vertebral Segments	subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Anterior Lumbar Or Thoracolumbar Vertebral Body	EIU: Procedure/service not reimbursed by the Plan. Not			
0657T	Tethering; 8 Or More Vertebral Segments	subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Electrical Impedance Spectroscopy Of 1 Or More Skin	MP Criteria: Procedure/service reviewed against Medical			
0658T	Lesions For Automated Melanoma Risk Score	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Donor Hysterectomy (Including Cold Preservation); Open	EIU: Procedure/service not reimbursed by the Plan. Not			
0664T	From Cadaver Donor	subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Donor Hysterectomy (Including Cold Preservation); Open	EIU: Procedure/service not reimbursed by the Plan. Not			
0665T	From Living Donor	subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Donor Hysterectomy (Including Cold Preservation);	EIU: Procedure/service not reimbursed by the Plan. Not			
0666T	Laparoscopic Or Robotic From Living Donor	subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Donor Hysterectomy (Including Cold Preservation); Recipient				
0667T	Uterus Allograft Transplantation From Cadaver Or Living	subject to pre-service review. Check EIU policy, which is	_	-	-
	Donor	one of our Clinical Payment and Coding Policy (CPCP).			

Backhanch Standard Prenaration Of Cadavar Or Living Donor				
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<u> </u>	* * *	-	-	-
	one of our clinical Payment and Coding Policy (CPCP).			
	FILL: Procedure/service not reimbursed by the Plan Not			
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	one of our chilical rayment and county rolley (crer).			
	EIU: Procedure/service not reimbursed by the Plan. Not			
	subject to pre-service review. Check EIU policy, which is	_	_	_
Neck And Proximal Orethra For Ormaly incontinence	one of our Clinical Payment and Coding Policy (CPCP).			
Therapeutic Ultrafiltration	MP Criteria: Procedure/service reviewed against Medical			
				Effective
		5/1/2024	_	5/1/2024
Remote Autonomous Algorithm-Based Recommendation				
_	-			
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<u> </u>	·			
•	·	_	_	_
	avoid post-service review.			
Bone Strength And Fracture Risk Using Finite Element				
Analysis Of Functional Data And Bone Mineral Density (Bmd)				
With Concurrent Vertebral Fracture Assessment Utilizing	SILL December 1 to 1 t			
Data From A Computed Tomography Scan Retrieval And	· ·			
Transmission Of The Scan Data Measurement Of Bone		-	-	-
Strength And Bmd And Classification Of Any Vertebral	one of our Clinical Payment and Coding Policy (CPCP).			
,				
Insertion Of Bioprosthetic Valve Open Femoral Vein				
Including Duplex Ultrasound Imaging Guidance When	EIU: Procedure/service not reimbursed by the Plan. Not			
Performed Including Autogenous Or Nonautogenous Patch	subject to pre-service review. Check EIU policy, which is	_	_	_
Graft (Eg Polyester Eptfe Bovine Pericardium) When	one of our Clinical Payment and Coding Policy (CPCP).			
Performed				
Cardiac Focal Ablation Utilizing Radiation Therapy For				
Arrhythmia; Noninvasive Arrhythmia Localization And	MD Critoria: Procedure/service reviewed against Medical			
Mapping Of Arrhythmia Site (Nidus) Derived From	·			
Anatomical Image Data (Eg Ct Mri Or Myocardial Perfusion	·	-	-	_
,	avoiu post-service review.			
	Uterine Allograft Prior To Transplantation Including Dissection And Removal Of Surrounding Soft Tissues And Preparation Of Uterine Vein(S) And Uterine Artery(Ies) As Necessary Backbench Reconstruction Of Cadaver Or Living Donor Uterus Allograft Prior To Transplantation; Venous Anastomosis Each Backbench Reconstruction Of Cadaver Or Living Donor Uterus Allograft Prior To Transplantation; Arterial Anastomosis Each Endovaginal Cryogen-Cooled Monopolar Radiofrequency Remodeling Of The Tissues Surrounding The Female Bladder Neck And Proximal Urethra For Urinary Incontinence Therapeutic Ultrafiltration Remote Autonomous Algorithm-Based Recommendation System For Insulin Dose Calculation And Titration; Initial Set- Up And Patient Education Remote Autonomous Algorithm-Based Recommendation System For Insulin Dose Calculation And Titration; Provision Of Software Data Collection Transmission And Storage Each 30 Days Bone Strength And Fracture Risk Using Finite Element Analysis Of Functional Data And Bone Mineral Density (Bmd) With Concurrent Vertebral Fracture Assessment Utilizing Data From A Computed Tomography Scan Retrieval And Transmission Of The Scan Data Measurement Of Bone Strength And Bmd And Classification Of Any Vertebral Fractures With Overall Fracture-Risk Assessment Interpretation And Report Insertion Of Bioprosthetic Valve Open Femoral Vein Including Duplex Ultrasound Imaging Guidance When Performed Including Autogenous Or Nonautogenous Patch Graft (Eg Polyester Eptfe Bovine Pericardium) When Performed Cardiac Focal Ablation Utilizing Radiation Therapy For Arrhythmia; Noninvasive Arrhythmia Localization And Mapping Of Arrhythmia Site (Nidus) Derived From	Dissection And Removal Of Surrounding Soft Tissues And Preparation Of Uterine Vein(S) And Uterine Artery(les) As Necessary Backbench Reconstruction Of Cadaver Or Living Donor Uterus Allograft Prior To Transplantation; Venous Anastomosis Each Backbench Reconstruction Of Cadaver Or Living Donor Uterus Allograft Prior To Transplantation; Venous Anastomosis Each Backbench Reconstruction Of Cadaver Or Living Donor Uterus Allograft Prior To Transplantation; Anastomosis Each Backbench Reconstruction Of Cadaver Or Living Donor Uterus Allograft Prior To Transplantation; Anastomosis Each Endovaginal Cryogen-Cooled Monopolar Radiofrequency Remodeling Of The Tissues Surrounding The Female Bladder Neck And Proximal Urethra For Urinary Incontinence Therapeutic Ultrafiltration Bemote Autonomous Algorithm-Based Recommendation System For Insulin Dose Calculation And Titration; Initial Set-Up And Patient Education Remote Autonomous Algorithm-Based Recommendation System For Insulin Dose Calculation And Titration; Provision Of Software Data Collection Transmission And Storage Each 3D Days Bone Strength And Fracture Risk Using Finite Element Analysis Of Functional Data And Bone Mineral Density (Bmd) With Concurrent Vertebral Fracture Assessment Ullizing Data From A Computed Tomography Scan Retrieval And Transmission Of The Scan Data Measurement Of Bone Strength And Bone Mal Classification of Any Vertebral Fracture Assessment Ullizing Data From A Computed Tomography Scan Retrieval And Transmission Of The Scan Data Measurement Of Bone Strength And Bone And Classification of Any Vertebral Fracture Assessment Ullizing Data From A Computed Tomography Scan Retrieval And Transmission Of The Scan Data Measurement Of Bone Strength And Bone Mal Classification Of Any Vertebral Fracture Assessment Uniterorectation And Report Interorectation And Repo	Uterine Allograft Prior To Transplantation Including Dissection And Removal of Surrounding Soft Tissues And Preparation Of Uterine Vein(S) And Uterine Artery(les). So Necessary Backbench Reconstruction Of Cadaver Or Living Donor Uterus Allograft Prior To Transplantation; Venous Anastomosis Each Backbench Reconstruction Of Cadaver Or Living Donor Uterus Allograft Prior To Transplantation; Venous Anastomosis Each Backbench Reconstruction Of Cadaver Or Living Donor Uterus Allograft Prior To Transplantation; Arterial Anastomosis Each Backbench Reconstruction Of Cadaver Or Living Donor Uterus Allograft Prior To Transplantation; Arterial Anastomosis Each Endovaginal Cryogen-Cooled Monopolar Radiofrequency Remodeling Of The Tissues Surrounding The Female Bladder Neck And Proximal Urethra For Urinary Incontinence Therapeutic Ultrafiltration We Remote Autonomous Algorithm-Based Recommendation System For Insulin Dose Calculation And Titration; Provision Of Software Data Collection Transmission And Storage Each 30 Days Bone Strength And Fracture Risk Using Finite Element Analysis Of Functional Data And Bone Mineral Density (Bmd) With Concurrent Vertebral Fracture Assessment Ultilizing Data From A Computed Tomography Scan Retrieval And Transmission of The Scan Data Measurement Of Bone Strength And Bmd And Classification Of Any Vertebral Fractures With Overall Fracture Risk Assessment Insertion Of Bioprosthetic Valve Open Femoral Vein Including Duplex Ultrasound Imaging Guidance When Performed Cardiac Focal Ablation Utilizing Radiation Therapy For Arrhythmia Site (Midus) Derived From Annatomical Image Data (Eg Ct Mri Or Myocardial Perfusion Anatomical Image Data (Eg Ct Mri Or Myocardial Perfusion Anastomosia Image Data (Eg Ct Mri Or Myocardial Perfusion Anastomosia Recomber Performed Annatomical Image Data (Eg Ct Mri Or Myocardial Perfusion Anastomosia Recomber Performed Annatomical Image Data (Eg Ct Mri Or Myocardial Perfusion Annatomical Image Data (Eg Ct Mri Or Myocardial Perfusion Annatomical Image Data (Eg Ct Mri Or	Userine Allograft Prior To Transplantation Including Dissection And Removed 10 Surrounding Soft Tissues And Preparation Of Uterine Vein(S) And Uterine Artery(les). As Necessary Backberch Reconstruction Of Cadaver Or Living Donor Uterus Allograft Prior To Transplantation; Venous Subject to pre-service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is Anastomosis Each Backberch Reconstruction Of Cadaver Or Living Donor Uterus Allograft Prior To Transplantation; Venous Anastomosis Each Backberch Reconstruction Of Cadaver Or Living Donor Uterus Allograft Prior To Transplantation; Venous On Control Cadaver Or Living Donor Uterus Allograft Prior To Transplantation; Venous On Control Cadaver Or Living Donor Uterus Allograft Prior To Transplantation; Venous On Control Cadaver Or Living Donor Uterus Allograft Prior To Transplantation; Venous On Cadaver Or Living Donor Uterus Allograft Prior To Transplantation; Venous On Cadaver Or Living Donor Or Clinical Payment and Coding Policy (CPCP). Up And Patient Education Or Software Data Collection Transmission And Storage Each 30 Days Bone Strength And Eracture Risk Assessment Uterus Allograft Prior Cadaver Or Venous Allograft Prior Cadaver Or Venous Prior Venous Prio

	Conduction Englished and Hills of an Individual Residual Conduction Englished			1	
	Cardiac Focal Ablation Utilizing Radiation Therapy For	MP Criteria: Procedure/service reviewed against Medical			
0746T	Arrhythmia; Conversion Of Arrhythmia Localization And	Policy Criteria. Submit for Recommended Clinical Review to			
	Mapping Of Arrhythmia Site (Nidus) Into A Multidimensional	avoid post-service review.	_	_	-
	Radiation Treatment Plan	· ·			
	Cardiac Focal Ablation Utilizing Radiation Therapy For	MP Criteria: Procedure/service reviewed against Medical			
0747T	Arrhythmia; Delivery Of Radiation Therapy Arrhythmia	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Injections Of Stem Cell Product Into Perianal Perifistular Soft	EIU: Procedure/service not reimbursed by the Plan. Not			
0748T	Tissue Including Fistula Preparation (Eg Removal Of Setons	subject to pre-service review. Check EIU policy, which is	_	_	_
	Fistula Curettage Closure Of Internal Openings)	one of our Clinical Payment and Coding Policy (CPCP).			
	Assistive Algorithmic Electrocardiogram Risk-Based				
	Assessment For Cardiac Dysfunction (Eg Low-Ejection				
	Fraction Pulmonary Hypertension Hypertrophic	MP Criteria: Procedure/service reviewed against Medical			
0764T	Cardiomyopathy); Related To Concurrently Performed	Policy Criteria. Submit for Recommended Clinical Review to	_	-	_
	Electrocardiogram (List Separately In Addition To Code For	avoid post-service review.			
	Primary Procedure)				
	Assistive Algorithmic Electrocardiogram Risk-Based				
0765T	Assessment For Cardiac Dysfunction (Eg Low-Ejection	MP Criteria: Procedure/service reviewed against Medical			
	Fraction Pulmonary Hypertension Hypertrophic	Policy Criteria. Submit for Recommended Clinical Review to			
07031		avoid post-service review.	-	-	-
	Cardiomyopathy); Related To Previously Performed	avoid post-service review.			
	Electrocardiogram Transcutaneous Magnetic Stimulation By Focused Low-				
	Frequency Electromagnetic Pulse Peripheral Nerve With	EIU: Procedure/service not reimbursed by the Plan. Not			
0766T	Identification And Marking Of The Treatment Location	subject to pre-service review. Check EIU policy, which is	_	_	_
	Including Noninvasive Electroneurographic Localization	one of our Clinical Payment and Coding Policy (CPCP).			
	(Nerve Conduction Localization) When Performed; First				
	Nerve				
	Transcutaneous Magnetic Stimulation By Focused Low-				
	Frequency Electromagnetic Pulse Peripheral Nerve With	511. 2 1 /			
	Identification And Marking Of The Treatment Location	EIU: Procedure/service not reimbursed by the Plan. Not			
0767T	Including Noninvasive Electroneurographic Localization	subject to pre-service review. Check EIU policy, which is	_	_	_
	(Nerve Conduction Localization) When Performed; Each	one of our Clinical Payment and Coding Policy (CPCP).			
	Additional Nerve (List Separately In Addition To Code For				
	Primary Procedure)				
	Virtual Reality Technology To Assist Therapy (List Separately	EIU: Procedure/service not reimbursed by the Plan. Not			
0770T	In Addition To Code For Primary Procedure)	subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Virtual Reality (Vr) Procedural Dissociation Services Provided				
	By The Same Physician Or Other Qualified Health Care				
	Professional Performing The Diagnostic Or Therapeutic				
	Service That The Vr Procedural Dissociation Supports	EIU: Procedure/service not reimbursed by the Plan. Not			
0771T	Requiring The Presence Of An Independent Trained	subject to pre-service review. Check EIU policy, which is	_	_	_
	Observer To Assist In The Monitoring Of The Patient'S Level	one of our Clinical Payment and Coding Policy (CPCP).			
	Of Dissociation Or Consciousness And Physiological Status;				
	Initial 15 Minutes Of Intraservice Time Patient Age 5 Years				
	Or Older				

0772Т	Virtual Reality (Vr) Procedural Dissociation Services Provided By The Same Physician Or Other Qualified Health Care Professional Performing The Diagnostic Or Therapeutic Service That The Vr Procedural Dissociation Supports Requiring The Presence Of An Independent Trained Observer To Assist In The Monitoring Of The Patient'S Level Of Dissociation Or Consciousness And Physiological Status; Each Additional 15 Minutes Intraservice Time (List Separately In Addition To Code For Primary Service)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
0773Т	Virtual Reality (Vr) Procedural Dissociation Services Provided By A Physician Or Other Qualified Health Care Professional Other Than The Physician Or Other Qualified Health Care Professional Performing The Diagnostic Or Therapeutic Service That The Vr Procedural Dissociation Supports; Initial 15 Minutes Of Intraservice Time Patient Age 5 Years Or Older	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
0774Т	Virtual Reality (Vr) Procedural Dissociation Services Provided By A Physician Or Other Qualified Health Care Professional Other Than The Physician Or Other Qualified Health Care Professional Performing The Diagnostic Or Therapeutic Service That The Vr Procedural Dissociation Supports; Each Additional 15 Minutes Intraservice Time (List Separately In Addition To Code For Primary Service)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	_
0776Т	Therapeutic Induction Of Intra-Brain Hypothermia Including Placement Of A Mechanical Temperature-Controlled Cooling Device To The Neck Over Carotids And Head Including Monitoring (Eg Vital Signs And Sport Concussion Assessment Tool 5 [Scat5]) 30 Minutes Of Treatment	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
0777Т	Real-Time Pressure-Sensing Epidural Guidance System (List Separately In Addition To Code For Primary Procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
0778T	Surface Mechanomyography (Smmg) With Concurrent Application Of Inertial Measurement Unit (Imu) Sensors For Measurement Of Multi-Joint Range Of Motion Posture Gait And Muscle Function	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
0779Т	Gastrointestinal Myoelectrical Activity Study Stomach Through Colon With Interpretation And Report	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
0781T	Bronchoscopy Rigid Or Flexible With Insertion Of Esophageal Protection Device And Circumferential Radiofrequency Destruction Of The Pulmonary Nerves Including Fluoroscopic Guidance When Performed; Bilateral Mainstem Bronchi	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	_	-

	Dranchassany Digid Or Flovible With Insertion Of				
	Bronchoscopy Rigid Or Flexible With Insertion Of	SILL December / control of the control of the Disc Not			
	Esophageal Protection Device And Circumferential	EIU: Procedure/service not reimbursed by the Plan. Not			
0782T	Radiofrequency Destruction Of The Pulmonary Nerves	subject to pre-service review. Check EIU policy, which is	_	_	_
	Including Fluoroscopic Guidance When Performed;	one of our Clinical Payment and Coding Policy (CPCP).			
	Unilateral Mainstem Bronchus				
	Transcutaneous Auricular Neurostimulation Set-Up	EIU: Procedure/service not reimbursed by the Plan. Not			
0783T	Calibration And Patient Education On Use Of Equipment	subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Insertion Or Replacement Of Percutaneous Electrode Array	MP Criteria: Procedure/service reviewed against Medical			
0784T	Spinal With Integrated Neurostimulator Including Imaging	Policy Criteria. Submit for Recommended Clinical Review to		_	
	Guidance When Performed	avoid post-service review.	4/1/2024		Add effective 04/01/2024
	Revision Or Removal Of Neurostimulator Electrode Array	MP Criteria: Procedure/service reviewed against Medical			
0785T	Spinal With Integrated Neurostimulator	Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review.	4/1/2024		Add effective 04/01/2024
	Insertion Or Replacement Of Percutaneous Electrode Array	MP Criteria: Procedure/service reviewed against Medical			
0786T	Sacral With Integrated Neurostimulator Including Imaging	Policy Criteria. Submit for Recommended Clinical Review to			
	Guidance When Performed	l ·	4/1/2024	_	Add effective 04/01/2024
	Revision Or Removal Of Neurostimulator Electrode Array	MP Criteria: Procedure/service reviewed against Medical	,, =, === :		, , ,
0787T	Sacral With Integrated Neurostimulator	Policy Criteria. Submit for Recommended Clinical Review to			
07071	Sacial With Integrated Neurostimulator	· ·	4/1/2024	-	Add effective 04/01/2024
	Electronic Analysis With Simple Programming Of Implanted	avoid post-service review.	7/ 1/ 2024		Add Circuive 04/01/2024
	Integrated Neurostimulation System (Eg. Electrode Array				
	And Receiver) Including Contact Group(S) Amplitude Pulse				
07007	Width Frequency (Hz) On/Off Cycling Burst Dose Lockout	MP Criteria: Procedure/service reviewed against Medical			
0788T	Patient-Selectable Parameters Responsive Neurostimulation	Policy Criteria. Submit for Recommended Clinical Review to		-	
	Detection Algorithms Closed-Loop Parameters And Passive	avoid post-service review.			
	Parameters When Performed By Physician Or Other				
	Qualified Health Care Professional Spinal Cord Or Sacral				
	Nerve 1-3 Parameters		4/1/2024		Add effective 04/01/2024
	Electronic Analysis With Complex Programming Of				
	Implanted Integrated Neurostimulation System (Eg				
	Electrode Array And Receiver) Including Contact Group(S)				
	Amplitude Pulse Width Frequency (Hz) On/Off Cycling	MP Criteria: Procedure/service reviewed against Medical			
0789T	Burst Dose Lockout Patient-Selectable Parameters	Policy Criteria. Submit for Recommended Clinical Review to			
07891	Responsive Neurostimulation Detection Algorithms Closed-	· ·		-	
	Loop Parameters And Passive Parameters When Performed	avoid post-service review.			
	By Physician Or Other Qualified Health Care Professional				
	Spinal Cord Or Sacral Nerve 4 Or More Parameters				
	Spirital cord of Sacrative ve 1 of More rarameters		4/1/2024		Add effective 04/01/2024
	Revision (Eg Augmentation Division Of Tether)				
	Replacement Or Removal Of Thoracolumbar Or Lumbar	EIU: Procedure/service not reimbursed by the Plan. Not			
0790Т	Vertebral Body Tethering Including Thoracoscopy When	subject to pre-service review. Check EIU policy, which is		-	
	Performed		5/15/2024		Add effective 05/15/2024
	Revision (Eg Augmentation Division Of Tether)		-, -,		
	Replacement Or Removal Of Thoracolumbar Or Lumbar	MP Criteria: Procedure/service reviewed against Medical			
0790T	Vertebral Body Tethering Including Thoracoscopy When	Policy Criteria. Submit for Recommended Clinical Review to			Add effective 02/15/2024
	, , , , , , , , , , , , , , , , , , , ,	avoid post-service review.	2/15/2024	5/14/2024	Retire effective 05/14/2024
	Performed	l .	L/ 13/ LULT	3/14/2024	netire effective 03/14/2024

	Motor-Cognitive Semi-Immersive Virtual Reality-Facilitated	EIU: Procedure/service not reimbursed by the Plan. Not			
0791T	Gait Training Each 15 Minutes (List Separately In Addition	subject to pre-service review. Check EIU policy, which is			
0/911	, , ,	The state of the s	_	-	-
	To Code For Primary Procedure) Percutaneous Transcatheter Thermal Ablation Of Nerves	one of our Clinical Payment and Coding Policy (CPCP).			
	Innervating The Pulmonary Arteries Including Right Heart	MP Criteria: Procedure/service reviewed against Medical		-	
0793T	, ,	Policy Criteria. Submit for Recommended Clinical Review to	_		_
	Catheterization Pulmonary Artery Angiography And All	avoid post-service review.			
	Imaging Guidance				
	Transcatheter Insertion Of Permanent Dual-Chamber			-	
	Leadless Pacemaker Including Imaging Guidance (Eg	MD Critoria, Procedure (consist reviewed against Madical			
07057	Fluoroscopy Venous Ultrasound Right Atrial Angiography	MP Criteria: Procedure/service reviewed against Medical			
0795T	Right Ventriculography Femoral Venography) And Device	Policy Criteria. Submit for Recommended Clinical Review to	_		-
	Evaluation (Eg Interrogation Or Programming) When	avoid post-service review.			
	Performed; Complete System (le Right Atrial And Right				
	Ventricular Pacemaker Components)				
	Transcatheter Insertion Of Permanent Dual-Chamber			_	
	Leadless Pacemaker Including Imaging Guidance (Eg				
	Fluoroscopy Venous Ultrasound Right Atrial Angiography	, , , , , , , , , , , , , , , , ,			
	Right Ventriculography Femoral Venography) And Device	MP Criteria: Procedure/service reviewed against Medical			
0796T	Evaluation (Eg Interrogation Or Programming) When	Policy Criteria. Submit for Recommended Clinical Review to	_		_
	Performed; Right Atrial Pacemaker Component (When An	avoid post-service review.			
	Existing Right Ventricular Single Leadless Pacemaker Exists				
	To Create A Dual-Chamber Leadless Pacemaker System)				
	Transcatheter Insertion Of Permanent Dual-Chamber			_	
	Leadless Pacemaker Including Imaging Guidance (Eg				
	Fluoroscopy Venous Ultrasound Right Atrial Angiography	MP Criteria: Procedure/service reviewed against Medical			
0797T	Right Ventriculography Femoral Venography) And Device	Policy Criteria. Submit for Recommended Clinical Review to			
0/9/1	Evaluation (Eg Interrogation Or Programming) When	·	_		-
	Performed; Right Ventricular Pacemaker Component (When	avoid post-service review.			
	Part Of A Dual-Chamber Leadless Pacemaker System)				
	Transcatheter Removal Of Permanent Dual-Chamber			-	
	Leadless Pacemaker Including Imaging Guidance (Eg	MP Criteria: Procedure/service reviewed against Medical			
0798T	Fluoroscopy Venous Ultrasound Right Atrial Angiography	Policy Criteria. Submit for Recommended Clinical Review to	_		
	Right Ventriculography Femoral Venography) When	avoid post-service review.			
	Performed; Complete System (le Right Atrial And Right				
	Ventricular Pacemaker Components)				
	Transcatheter Removal Of Permanent Dual-Chamber			-	
	Leadless Pacemaker Including Imaging Guidance (Eg	MP Criteria: Procedure/service reviewed against Medical			
0799T	Fluoroscopy Venous Ultrasound Right Atrial Angiography	Policy Criteria. Submit for Recommended Clinical Review to	-		_
	Right Ventriculography Femoral Venography) When	avoid post-service review.			
	Performed; Right Atrial Pacemaker Component				

0800Т	Transcatheter Removal Of Permanent Dual-Chamber Leadless Pacemaker Including Imaging Guidance (Eg 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.	-	_	-
0801T	Transcatheter Removal And Replacement Of Permanent Dual-Chamber Leadless Pacemaker Including Imaging Guidance (Eg Fluoroscopy Venous Ultrasound Right Atrial Angiography Right Ventriculography Femoral Venography) And Device Evaluation (Eg Interrogation Or Programming) When Performed; Dual-Chamber System (Ie 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.	-	_	_
0802Т	Transcatheter Removal And Replacement Of Permanent Dual-Chamber Leadless Pacemaker Including Imaging Guidance (Eg Fluoroscopy Venous Ultrasound Right Atrial Angiography Right Ventriculography Femoral Venography) And Device Evaluation (Eg 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.	-	-	-
0803Т	Transcatheter Removal And Replacement Of Permanent Dual-Chamber Leadless Pacemaker Including Imaging Guidance (Eg Fluoroscopy Venous Ultrasound Right Atrial Angiography Right Ventriculography Femoral Venography) And Device Evaluation (Eg 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.	-	-	_
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.	-	_	_
0805T	Transcatheter Superior And Inferior Vena Cava Prosthetic Valve Implantation (Ie 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.	-	_	-
0806Т	Transcatheter Superior And Inferior Vena Cava Prosthetic Valve Implantation (Ie 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.	-	_	-

	Dulas anon Tiesus Ventilation Analysis Hairs Coffman Decad	FILL Described and John State and Assistance of the Disco Not			
	Pulmonary Tissue Ventilation Analysis Using Software-Based				
	Processing Of Data From Separately Captured	subject to pre-service review. Check EIU policy, which is			
	Cinefluorograph Images; In Combination With Previously	one of our Clinical Payment and Coding Policy (CPCP).			
0807T	Acquired Computed Tomography (Ct) Images Including Data		_	_	_
	Preparation And Transmission Quantification Of Pulmonary				
	Tissue Ventilation Data Review Interpretation And Report				
	Pulmonary Tissue Ventilation Analysis Using Software-Based	EIU: Procedure/service not reimbursed by the Plan. Not			
	Processing Of Data From Separately Captured	subject to pre-service review. Check EIU policy, which is			
	Cinefluorograph Images; In Combination With Computed	one of our Clinical Payment and Coding Policy (CPCP).			
0000T	Tomography (Ct) Images Taken For The Purpose Of				
0808T	Pulmonary Tissue Ventilation Analysis Including Data		_	-	-
	Preparation And Transmission Quantification Of Pulmonary				
	Tissue Ventilation Data Review Interpretation And Report				
	Arthrodesis, sacroiliac joint, percutaneous or minimally	EIU: Procedure/service not reimbursed by the Plan. Not			
0809T	invasive (indirect visualization), with image guidance,	subject to pre-service review. Check EIU policy, which is			
	placement of transfixing device(s) and intraarticular	one of our Clinical Payment and Coding Policy (CPCP).	_		_
	implant(s), including allograft or synthetic device(s)	, , , ,			
	Subretinal Injection Of A Pharmacologic Agent Including	MP Criteria: Procedure/service reviewed against Medical		_	
0810T	Vitrectomy And 1 Or More Retinotomies	Policy Criteria. Submit for Recommended Clinical Review to	_		_
		avoid post-service review.			
	Esophagogastroduodenoscopy Flexible Transoral With	MP Criteria: Procedure/service reviewed against Medical			
0813T	Volume Adjustment Of Intragastric Bariatric Balloon	Policy Criteria. Submit for Recommended Clinical Review to			
			4/1/2024	6/30/2024	Add effective 04/01/2024
	Esophagogastroduodenoscopy Flexible Transoral With	EIU: Procedure/service not reimbursed by the Plan. Not			
0813T	Volume Adjustment Of Intragastric Bariatric Balloon	subject to pre-service review. Check EIU policy, which is		_	
		one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024		Add effective 07/01/2024
	Open Insertion Or Replacement Of Integrated				
	Neurostimulation System For Bladder Dysfunction Including	MP Criteria: Procedure/service reviewed against Medical			
0816T	Electrode(S) (Eg Array Or Leadless) And Pulse Generator Or	Policy Criteria. Submit for Recommended Clinical Review to			
	Receiver Including Analysis Programming And Imaging	avoid post-service review.			
	Guidance When Performed Posterior Tibial Nerve;	· ·			Add effective 05/15/2024
	Subcutaneous		5/15/2024	6/30/2024	Retire effective 06/30/2024
	Open Insertion Or Replacement Of Integrated				
	Neurostimulation System For Bladder Dysfunction Including	EIU: Procedure/service not reimbursed by the Plan. Not			
0816T	Electrode(S) (Eg Array Or Leadless) And Pulse Generator Or	subject to pre-service review. Check EIU policy, which is			
	Receiver Including Analysis Programming And Imaging	one of our Clinical Payment and Coding Policy (CPCP).		-	
	Guidance When Performed Posterior Tibial Nerve;				
	Subcutaneous		7/1/2024		Add effective 07/01/2024
	Revision Or Removal Of Integrated Neurostimulation System	MP Criteria: Procedure/service reviewed against Medical			
0818T	For Bladder Dysfunction Including Analysis Programming	Policy Criteria. Submit for Recommended Clinical Review to			
00101	And Imaging When Performed Posterior Tibial Nerve;	avoid nost sonice review			Add effective 05/15/2024
	Subcutaneous	avoia post-service review.	5/15/2024	6/30/2024	Retire effective 06/30/2024

0818T	Revision Or Removal Of Integrated Neurostimulation System For Bladder Dysfunction Including Analysis Programming And Imaging When Performed Posterior Tibial Nerve; Subcutaneous	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	- 7/1/2024		Add effective 07/01/2024
0823T	Transcatheter Insertion Of Permanent Single-Chamber Leadless Pacemaker Right Atrial Including Imaging Guidance (Eg Fluoroscopy Venous Ultrasound Right Atrial Angiography And/Or Right Ventriculography Femoral Venography Cavography) And Device Evaluation (Eg Interrogation Or Programming) When Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2024		Effective 5/15/2024
0824T	Transcatheter Removal Of Permanent Single-Chamber Leadless Pacemaker Right Atrial Including Imaging Guidance (Eg Fluoroscopy Venous Ultrasound Right Atrial Angiography And/Or Right Ventriculography Femoral Venography Cavography) When Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	- 5/15/2024		Effective 5/15/2024
0825T	Transcatheter Removal And Replacement Of Permanent Single-Chamber Leadless Pacemaker Right Atrial Including Imaging Guidance (Eg Fluoroscopy Venous Ultrasound Right Atrial Angiography And/Or Right Ventriculography Femoral Venography Cavography) And Device Evaluation (Eg Interrogation Or Programming) When Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2024		Effective 5/15/2024
0826Т	Programming Device Evaluation (In Person) With Iterative Adjustment Of The Implantable Device To Test The Function Of The Device And Select Optimal Permanent Programmed Values With Analysis Review And Report By A Physician Or Other Qualified Health Care Professional Leadless Pacemaker System In Single-Cardiac Chamber	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2024		Effective 5/15/2024
0861T	Removal Of Pulse Generator For Wireless Cardiac Stimulator For Left Ventricular Pacing; Both Components (Battery And Transmitter)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.			Add effective 04/01/2024
0862Т	Relocation Of Pulse Generator For Wireless Cardiac Stimulator For Left Ventricular Pacing Including Device Interrogation And Programming; Battery Component Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024		Add effective 04/01/2024
0863Т	Relocation Of Pulse Generator For Wireless Cardiac Stimulator For Left Ventricular Pacing Including Device Interrogation And Programming; Transmitter Component Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_ 4/1/2024		Add effective 04/01/2024
0864T	Low-Intensity Extracorporeal Shock Wave Therapy Involving Corpus Cavernosum Low Energy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	6/30/2024	Add effective 04/01/2024
0864T	Low-Intensity Extracorporeal Shock Wave Therapy Involving Corpus Cavernosum Low Energy	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024		Add effective 07/01/2024
213AA	Proc/Treat/Equip/Ins/Non-Covered	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.			-

	Otc Drugs Non-Covered	Non Covered: Procedure/service not covered by the Plan.			
213BA	ott brugs Non-Covered	Not subject to pre-service review.	_	_	_
	Vision/Hear/Dental Non-Covered	Non Covered: Procedure/service not covered by the Plan.			
213CA	Vision/Hear/ Dental Non-covered	Not subject to pre-service review.	_	_	_
	Assit Disabled/Misc Non-Covered	Non Covered: Procedure/service not covered by the Plan.			
213EA	Assit Disabled/Wisc Non-Covered	Not subject to pre-service review.	_	_	_
	Corr Eye Surgery Non-Covered	Non Covered: Procedure/service not covered by the Plan.			
213FA	Con Lye Surgery Non-Covered	Not subject to pre-service review.	_	_	_
	Premiums Non- Covered	Non Covered: Procedure/service not covered by the Plan.			
213GA	Tremiums Non- Covered	Not subject to pre-service review.	_	_	_
	Copays Non-Covered	Non Covered: Procedure/service not covered by the Plan.			
213HA	copuys won covered	Not subject to pre-service review.	_	_	_
	Limited Purpose Hca Non- Covered	Non Covered: Procedure/service not covered by the Plan.			
213JA	Limited Full pose field from Covered	Not subject to pre-service review.	_	_	_
	Preventative Care Non-Covered	Non Covered: Procedure/service not covered by the Plan.			
213KA	Treventative care from covered	Not subject to pre-service review.	_	_	_
	Long Term Care Non-Covered	Non Covered: Procedure/service not covered by the Plan.			
213LA	Long remi care from covered	Not subject to pre-service review.	_	_	_
	Non-Prescription Drugs	Non Covered: Procedure/service not covered by the Plan.			
9701A	1.00.1.1.000.1.01.01.01.01	Not subject to pre-service review.	_	_	_
	Ambulance Service Advanced Life Support Non-Emergency	MP Criteria: Procedure/service reviewed against Medical			
A0426	Transport Level 1 (Als 1)	Policy Criteria. Submit for Recommended Clinical Review to			
	1.4.1562.5 26.5 27.	avoid post-service review.	_	_	[⁻
	Ambulance Service Conventional Air Services Transport	MP Criteria: Procedure/service reviewed against Medical			
A0430	One Way (Fixed Wing)	Policy Criteria. Submit for Recommended Clinical Review to			
	, , , , , , , , , , , , , , , , , , , ,	avoid post-service review.	_	_	_
	Ambulance Service Conventional Air Services Transport	MP Criteria: Procedure/service reviewed against Medical			
A0431	One Way (Rotary Wing)	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Fixed Wing Air Mileage Per Statute Mile	MP Criteria: Procedure/service reviewed against Medical			
A0435		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Rotary Wing Air Mileage Per Statute Mile	MP Criteria: Procedure/service reviewed against Medical			
A0436		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Noncovered Ambulance Mileage Per Mile (E. G. For Miles	MP Criteria: Procedure/service reviewed against Medical			
A0888	Traveled Beyond Closest Appropriate Facility)	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
A0999	Unlisted Ambulance Service	Unlisted: Procedure/service not specifically defined or			
A0333		classified, maybe subject to contract/clinical review.	-	-	_
	Innovamatrix Ac Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
A2001		subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Mirragen Advanced Wound Matrix Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
A2002		subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
		one or our chilicar rayment and coding rolley (creer).			

	Xcellistem 1 Mg	EIU: Procedure/service not reimbursed by the Plan. Not			
A2004	Accustem 1 Mg	subject to pre-service review. Check EIU policy, which is			
712001		one of our Clinical Payment and Coding Policy (CPCP).	_	-	-
	Microlyte Matrix Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
A2005	Wherefyte Wath X Tel Square certaineter	subject to pre-service review. Check EIU policy, which is			
712003		one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
	Novosorb Synpath Dermal Matrix Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
A2006	Novosorb Sympath Definal Matrix 1 er Square Centimeter	subject to pre-service review. Check EIU policy, which is			
A2000		one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
	Restrata Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
A2007	Restrata Per Square Certifficter	subject to pre-service review. Check EIU policy, which is			
A2007		one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
	Thoragonocis Por Square Contimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
A2008	Theragenesis Per Square Centimeter	subject to pre-service review. Check EIU policy, which is			
A2008			-	-	-
	Company Day Carrage Continuation	one of our Clinical Payment and Coding Policy (CPCP).			
A 2000	Symphony Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
A2009		subject to pre-service review. Check EIU policy, which is	-	-	-
	Asia Basica and Castinasta	one of our Clinical Payment and Coding Policy (CPCP).			
10010	Apis Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
A2010		subject to pre-service review. Check EIU policy, which is	_	-	-
		one of our Clinical Payment and Coding Policy (CPCP).			
	Supra Sdrm Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
A2011		subject to pre-service review. Check EIU policy, which is	_	_	-
		one of our Clinical Payment and Coding Policy (CPCP).			
	Suprathel Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
A2012		subject to pre-service review. Check EIU policy, which is	_	_	-
		one of our Clinical Payment and Coding Policy (CPCP).			
	Innovamatrix Fs Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
A2013		subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Omeza Collagen Matrix Per 100 Mg	EIU: Procedure/service not reimbursed by the Plan. Not			
A2014		subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Phoenix Wound Matrix Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
A2015		subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Permeaderm B Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
A2016		subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Permeaderm Glove Each	EIU: Procedure/service not reimbursed by the Plan. Not			
A2017		subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Permeaderm C Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
A2018		subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Kerecis Omega3 Marigen Shield Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
A2019		subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
			*		

	Ac5 Advanced Wound System (Ac5)	EIU: Procedure/service not reimbursed by the Plan. Not			
A2020		subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Neomatrix Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
A2021		subject to pre-service review. Check EIU policy, which is			
		one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
	Innovaburn Or Innovamatrix XI Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
A2022	illiovabulii oi illiovallatiix XI i el Squale celitilletel	subject to pre-service review. Check EIU policy, which is			
A2022		The state of the s	-	-	-
		one of our Clinical Payment and Coding Policy (CPCP).			
	Innovamatrix Pd 1 Mg	EIU: Procedure/service not reimbursed by the Plan. Not			
A2023		subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Resolve Matrix Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
A2024		subject to pre-service review. Check EIU policy, which is	_		_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Miro3D Per Cubic Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
A2025		subject to pre-service review. Check EIU policy, which is			
A2025		one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
	Destrote Minimestric F Ma	, , , ,			
	Restrata Minimatrix 5 Mg	EIU: Procedure/service not reimbursed by the Plan. Not			
A2026		subject to pre-service review. Check EIU policy, which is		_	
		one of our Clinical Payment and Coding Policy (CPCP).	4/1/2024		Add effective 04/01/2024
	Skin Substitute Fda Cleared As A Device Not Otherwise	EIU: Procedure/service not reimbursed by the Plan. Not			
A4100	Specified	subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Sacral Nerve Stimulation Test Lead Each	MP Criteria: Procedures/services reviewed against Medical			
A4290		Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review by BCBS.	_	_	_
	Incontinence Supply; Miscellaneous	Unlisted: Procedure/service not specifically defined or			
A4335	incontinence Supply, Miscellaneous		_	_	_
	Led allies later with all Darlance De lan Müle Value Darland	classified, maybe subject to contract/clinical review.			
	Indwelling Intraurethral Drainage Device With Valve Patient				
A4341	Inserted Replacement Only Each	Policy Criteria. Submit for Recommended Clinical Review to	-	_	_
		avoid post-service review.			
	Accessories For Patient Inserted Indwelling Intraurethral	MP Criteria: Procedure/service reviewed against Medical			
A4342	Drainage Device With Valve Replacement Only Each	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Ostomy Supply; Miscellaneous	Unlisted: Procedure/service not specifically defined or			
A4421	,,	classified, maybe subject to contract/clinical review.	_	_	-
	Enema Bag With Tubing Reusable	Non Covered: Procedure/service not covered by the Plan.			
A4458	Literia bag with rabing neasable	Not subject to pre-service review.	_	_	_
	Incombination Comment And Time (F.C. Brief Biograph Fook	· · ·			
A4520	Incontinence Garment Any Type (E.G. Brief Diaper) Each	Non Covered: Procedure/service not covered by the Plan.	_		
		Not subject to pre-service review.			
	Distal Transcutaneous Electrical Nerve Stimulator	EIU: Procedure/service not reimbursed by the Plan. Not			
A4540	Stimulates Peripheral Nerves Of The Upper Arm	subject to pre-service review. Check EIU policy, which is		_	
		one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024		Add effective 05/15/2024
	Distal Transcutaneous Electrical Nerve Stimulator	MP Criteria: Procedure/service reviewed against Medical			
A4540	Stimulates Peripheral Nerves Of The Upper Arm	Policy Criteria. Submit for Recommended Clinical Review to			Add effective 02/15/2024
	,	avoid post-service review.	2/15/2024	5/14/2024	Retire effective 05/14/2024
		arola post service review.	,,	3, 2 ., 202	1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1

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	Monthly Supplies For Use Of Device Coded At E0733	MP Criteria: Procedure/service reviewed against Medical			
A4541		Policy Criteria. Submit for Recommended Clinical Review to		_	
		avoid post-service review.	2/15/2024		Add effective 02/15/2024
	Supplies And Accessories For External Upper Limb Tremor	EIU: Procedure/service not reimbursed by the Plan. Not			
A4542	Stimulator Of The Peripheral Nerves Of The Wrist	subject to pre-service review. Check EIU policy, which is		_	
		one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024		Add effective 05/15/2024
	Supplies And Accessories For External Upper Limb Tremor	MP Criteria: Procedure/service reviewed against Medical			
A4542	Stimulator Of The Peripheral Nerves Of The Wrist	Policy Criteria. Submit for Recommended Clinical Review to			Add effective 02/15/2024
	·	avoid post-service review.	2/15/2024	5/14/2024	Retire effective 05/14/2024
	Non-Disposable Underpads All Sizes	Non Covered: Procedure/service not covered by the Plan.			
A4553		Not subject to pre-service review.	-	_	-
	Disposable Underpads All Sizes	Non Covered: Procedure/service not covered by the Plan.			
A4554		Not subject to pre-service review.	_	_	_
	Electrode/Transducer For Use With Electrical Stimulation	MP Criteria: Procedure/service reviewed against Medical			
A4555	Device Used For Cancer Treatment Replacement Only	Policy Criteria. Submit for Recommended Clinical Review to			
711333	bevice oscaror cancer readment replacement only	avoid post-service review.	-	-	-
	Neuromuscular Electrical Stimulator (Nmes) Disposable	EIU: Procedure/service not reimbursed by the Plan. Not			
A4560		· · · · · · · · · · · · · · · · · · ·			
A450U	Replacement Only	subject to pre-service review. Check EIU policy, which is	1 /15 /2024	-	Add offortive 1/15/2024
	No construction for the first field (1) and the second for the sec	one of our Clinical Payment and Coding Policy (CPCP).	1/15/2024		Add effective 1/15/2024
	Neuromuscular Electrical Stimulator (Nmes) Disposable	MP Criteria: Procedure/service reviewed against Medical			Add affaction 10/15/2022
A4560	Replacement Only	Policy Criteria. Submit for Recommended Clinical Review to	-		Add effective 10/15/2023
		avoid post-service review.		1/14/2024	Retire effective 01/14/2024
	Topical Hyperbaric Oxygen Chamber Disposable	EIU: Procedure/service not reimbursed by the Plan. Not			
A4575		subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Cranial Electrotherapy Stimulation (Ces) System Supplies	EIU: Procedure/service not reimbursed by the Plan. Not			
A4596	And Accessories Per Month	subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Sleeve For Intermittent Limb Compression Device	MP Criteria: Procedure/service reviewed against Medical			
A4600	Replacement Only Each	Policy Criteria. Submit for Recommended Clinical Review to			
	· · · · · · · · · · · · · · · · · · ·	avoid post-service review.			
	Replacement Battery For Patient-Owned Ear Pulse	MP Criteria: Procedure/service reviewed against			
A4638	Generator Each	•			
A4030	Generator Each	Medical Policy Criteria. Submit for Recommended	5 /4 /2024	-	A -l
		Clinical Review to avoid post-service review.	5/1/2024		Add effective 05/01/2024
	Replacement Pad For Infrared Heating Pad System Each	EIU: Procedure/service not reimbursed by the Plan. Not			
A4639		subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
A4641	Radiopharmaceutical Diagnostic Not Otherwise Classified	Unlisted: Procedure/service not specifically defined or			
A4041		classified, maybe subject to contract/clinical review.	-	-	-
A4640	Surgical Supply; Miscellaneous	Unlisted: Procedure/service not specifically defined or			
A4649		classified, maybe subject to contract/clinical review.	-	-	-
4.4000	Contracts Repair And Maintenance For Hemodialysis	Non Covered: Procedure/service not covered by the Plan.			
A4890	Equipment	Not subject to pre-service review.	-	-	-
	Miscellaneous Dialysis Supplies Not Otherwise Specified	Unlisted: Procedure/service not specifically defined or			
A4913	Section courses supplied Not otherwise specified	classified, maybe subject to contract/clinical review.	_	_	_
	Gloves Non-Sterile Per 100	Non Covered: Procedure/service not covered by the Plan.			
A4927	CIONES MOLI-STELLIE LEI TOO	· ·	_	_	_
		Not subject to pre-service review.			

A4931	Oral Thermometer Reusable Any Type Each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
A4932	Rectal Thermometer Reusable Any Type Each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	_	_
A5507	For Diabetics Only Not Otherwise Specified Modification (Including Fitting) Of Off-The-Shelf Depth-Inlay Shoe Or Custom-Molded Shoe Per Shoe	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-
A6000	Non-Contact Wound Warming Wound Cover For Use With The Non-Contact Wound Warming Device And Warming Card	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	-	-
A6261	Wound Filler Gel/Paste Per Fluid Ounce Not Otherwise Specified	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	_	-
A6262	Wound Filler Dry Form Per Gram Not Otherwise Specified	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
A6512	Compression Burn Garment Not Otherwise Classified	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	-	_
A6549	Gradient Compression Garment Not Otherwise Specified	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	-	_
A7049	Expiratory Positive Airway Pressure Intranasal Resistance Valve	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
A9150	Non-Prescription Drugs	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	-	_
A9152	Single Vitamin/Mineral/Trace Element Oral Per Dose Not Otherwise Specified	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted or Undefined: Procedures/services not specifically defined or classified, maybe subject to contract/clinical review.	-	_	-
A9153	Multiple Vitamins With Or Without Minerals And Trace Elements Oral Per Dose Not Otherwise Specified	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted or Undefined: Procedures/services not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-
A9270	Non-Covered Item Or Service	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	-
A9273	Cold Or Hot Fluid Bottle Ice Cap Or Collar Heat And/Or Cold Wrap Any Type	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	-	-
A9279	Monitoring Feature/Device Stand-Alone Or Integrated Any Type Includes All Accessories Components And Electronics Not Otherwise Classified	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	-	-
A9280	Alert Or Alarm Device Not Otherwise Classified	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	-
A9282	Wig Any Type Each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	-	-
A9285	Inversion/Eversion Correction Device	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	-

	Prescription Digital Cognitive And/Or Behavioral Therapy	EIU: Procedure/service not reimbursed by the Plan. Not			
A9291	Fda Cleared Per Course Of Treatment	subject to pre-service review. Check EIU policy, which is			Retire effective
A3231	Tua cleared Fer Course of Treatment	one of our Clinical Payment and Coding Policy (CPCP).	-	1/31/2024	1/31/2024
	Prescription Digital Cognitive And/Or Behavioral Therapy	MP Criteria: Procedure/service reviewed against Medical		1/31/2021	1,31,2021
A9291	Fda Cleared Per Course Of Treatment	Policy Criteria. Submit for Recommended Clinical Review to			
AJ2J1	rua cleateu Pet Course Of Treatment	avoid post-service review.	2/1/2024	-	Add effective 02/1/2024
	Exercise Equipment	Non Covered: Procedure/service not covered by the Plan.	2/1/2024		Add effective 02/1/2024
A9300	Exercise Equipment	Not subject to pre-service review.	_	_	_
	Ladina I 121 Jahanguana Sulfata Diagnostia Day O.F.	MP Criteria: Procedures/services reviewed against Medical			
A9508	Iodine I-131 Iobenguane Sulfate Diagnostic Per 0.5	Policy Criteria. Submit for Recommended Clinical Review to			
A9306	Millicurie		_	-	_
	Litations Li 177 Datatata Thananautic 1 Milliannia	avoid post-service review by Carelon. MP Criteria: Procedures/services reviewed against Medical			
10512	Lutetium Lu 177 Dotatate Therapeutic 1 Millicurie	_			
A9513		Policy Criteria. Submit for Recommended Clinical Review to	-	-	_
	Ladia L 424 Cadia a Ladida Cara la (C) Diagnatia Dan	avoid post-service review by Carelon. MP Criteria: Procedures/services reviewed against Medical			
10530	Iodine I-131 Sodium Iodide Capsule(S) Diagnostic Per				
A9528	Millicurie	Policy Criteria. Submit for Recommended Clinical Review to	_	-	_
	Ladia - L424 Cadia - Ladida Diagnatia Day Missa - da (U.	avoid post-service review by Carelon.			
.0504	lodine I-131 Sodium Iodide Diagnostic Per Microcurie (Up	MP Criteria: Procedures/services reviewed against Medical			
A9531	To 100 Microcuries)	Policy Criteria. Submit for Recommended Clinical Review to	_	-	_
	W	avoid post-service review by Carelon.			
	Yttrium Y-90 Ibritumomab Tiuxetan Therapeutic Per	MP Criteria: Procedures/services reviewed against Medical			
A9543	Treatment Dose Up To 40 Millicuries	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by Carelon.			
A9579	Injection Gadolinium-Based Magnetic Resonance Contrast	Unlisted: Procedure/service not specifically defined or			
	Agent Not Otherwise Specified (Nos) Per MI	classified, maybe subject to contract/clinical review.	_	_	_
	lodine I-131 lobenguane 1 Millicurie	MP Criteria: Procedures/services reviewed against Medical			
A9590		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by Carelon.			
	Positron Emission Tomography Radiopharmaceutical	Unlisted: Procedure/service not specifically defined or			
A9597	Diagnostic For Tumor Identification Not Otherwise	classified, maybe subject to contract/clinical review.	_	_	_
	Classified	,,			
	Positron Emission Tomography Radiopharmaceutical	Unlisted: Procedure/service not specifically defined or			
A9598	Diagnostic For Non-Tumor Identification Not Otherwise	classified, maybe subject to contract/clinical review.	_	_	_
	Classified	i i i i i i i i i i i i i i i i i i i			
	Strontium Sr-89 Chloride Therapeutic Per Millicurie	MP Criteria: Procedures/services reviewed against Medical			
A9600		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by Carelon.			
	Fluorodopa F-18 Diagnostic Per Millicurie	MP Criteria: Procedures/services reviewed against Medical			
A9602		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by Carelon.			
	Samarium Sm-153 Lexidronam Therapeutic Per Treatment	MP Criteria: Procedures/services reviewed against Medical			
A9604	Dose Up To 150 Millicuries	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by Carelon.			
	Radium Ra-223 Dichloride Therapeutic Per Microcurie	MP Criteria: Procedures/services reviewed against Medical			
A9606		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by Carelon.			

	Lutetium Lu 177 Vipivotide Tetraxetan Therapeutic 1	MP Criteria: Procedures/services reviewed against Medical			
A9607	Millicurie	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by Carelon.			
A9698	Non-Radioactive Contrast Imaging Material Not Otherwise	Unlisted: Procedure/service not specifically defined or			
A3030	Classified Per Study	classified, maybe subject to contract/clinical review.	-	-	_
A9699	Radiopharmaceutical Therapeutic Not Otherwise Classified	Unlisted: Procedure/service not specifically defined or			
A3033		classified, maybe subject to contract/clinical review.	-	-	_
	Gallium Ga-68 Gozetotide Diagnostic (Locametz) 1	MP Criteria: Procedures/services reviewed against Medical			
A9800	Millicurie	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by Carelon.			
A9900	Miscellaneous Dme Supply Accessory And/Or Service	Unlisted: Procedure/service not specifically defined or			
A9900	Component Of Another Hcpcs Code	classified, maybe subject to contract/clinical review.	-	-	-
40000	Miscellaneous Dme Supply Or Accessory Not Otherwise	Unlisted: Procedure/service not specifically defined or			
A9999	Specified	classified, maybe subject to contract/clinical review.	-	-	-
D0000	Noc For Enteral Supplies	Unlisted: Procedure/service not specifically defined or			
B9998		classified, maybe subject to contract/clinical review.	_	-	-
20000	Noc For Parenteral Supplies	Unlisted: Procedure/service not specifically defined or			
B9999	·	classified, maybe subject to contract/clinical review.	_	-	_
	Hemostatic Agent Gastrointestinal Topical	EIU: Procedure/service not reimbursed by the Plan. Not			
C1052	·	subject to pre-service review. Check EIU policy, which is			
		one of our Clinical Payment and Coding Policy (CPCP).	_	Г	_
	Intravertebral Body Fracture Augmentation With	MP Criteria: Procedure/service reviewed against			
C1062	Implant (E.G. Metal Polymer)	Medical Policy Criteria. Submit for Recommended			
C1002	implant (E.G. Metal Tolymer)	·	4/1/2024	-	Add effective 04/01/2024
		Clinical Review to avoid post-service review.	4/1/2024		Add effective 04/01/2024
01761	Catheter Transluminal Intravascular Lithotripsy Coronary	MP Criteria: Procedure/service reviewed against Medical			
C1761		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Event Recorder Cardiac	MP Criteria: Procedure/service reviewed against Medical			
C1764		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Joint Device (Implantable)	MP Criteria: Procedure/service reviewed against Medical			
C1776		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Lead Neurostimulator	MP Criteria: Procedure/service reviewed against Medical			
C1778		Policy Criteria. Submit for Recommended Clinical Review to		_	
		avoid post-service review.	4/1/2024		Add effective 04/01/2024
	Ocular Implant Aqueous Drainage Assist Device	MP Criteria: Procedure/service reviewed against Medical			
C1783		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Integrated Keratoprosthesis	MP Criteria: Procedure/service reviewed against Medical			
C1818		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Generator Neurostimulator (Implantable) With	MP Criteria: Procedure/service reviewed against Medical			
C1820	Rechargeable Battery And Charging System	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			

	Generator Neurostimulator (Implantable) High Frequency	MP Criteria: Procedure/service reviewed against Medical			
C1822	With Rechargeable Battery And Charging System	Policy Criteria. Submit for Recommended Clinical Review to			
C1622	With Rechargeable battery And Charging System	avoid post-service review.	_	-	-
	Generator Neurostimulator (Implantable) Non-	EIU: Procedure/service not reimbursed by the Plan. Not			
C1823	Rechargeable With Transvenous Sensing And Stimulation	subject to pre-service review. Check EIU policy, which is			
C1623		one of our Clinical Payment and Coding Policy (CPCP).	-	-	_
	Leads	MP Criteria: Procedure/service reviewed against Medical			
C193F	Generator Neurostimulator (Implantable) Non-	Policy Criteria. Submit for Recommended Clinical Review to			
C1825	Rechargeable With Carotid Sinus Baroreceptor Stimulation	,	-	-	-
	Lead(S)	avoid post-service review.			
	Generator Neurostimulator (Implantable) Includes Closed	MP Criteria: Procedure/service reviewed against Medical			
C1826	Feedback Loop Leads And All Implantable Components	Policy Criteria. Submit for Recommended Clinical Review to			
	With Rechargeable Battery And Charging System	avoid post-service review.			[
	Generator Neurostimulator (Implantable) Non-	EIU: Procedure/service not reimbursed by the Plan. Not			
C1827	Rechargeable With Implantable Stimulation Lead And	subject to pre-service review. Check EIU policy, which is	_	-	_
	External Paired Stimulation Controller	one of our Clinical Payment and Coding Policy (CPCP).			
	Autograft Suspension Including Cell Processing And	EIU: Procedure/service not reimbursed by the Plan. Not			
C1832	Application And All System Components	subject to pre-service review. Check EIU policy, which is		_	
		, , , ,	5/15/2024		Add effective 05/15/2024
	Autograft Suspension Including Cell Processing And	MP Criteria: Procedure/service reviewed against Medical			
C1832	Application And All System Components	Policy Criteria. Submit for Recommended Clinical Review to			Add effective 02/1/2024
			2/1/2024	5/14/2024	Retire effective 05/14/2024
	Monitor Cardiac Including Intracardiac Lead And All System	MP Criteria: Procedure/service reviewed against Medical			
C1833	Components (Implantable)	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
C1889	Implantable/Insertable Device Not Otherwise Classified	Unlisted: Procedure/service not specifically defined or			
02000		classified, maybe subject to contract/clinical review.	-	-	-
	Catheter Transluminal Angioplasty Drug-Coated Non-Laser				
C2623		Policy Criteria. Submit for Recommended Clinical Review to		_	
		· · · · ·	2/1/2024		Add effective 02/1/2024
	Implantable Wireless Pulmonary Artery Pressure Sensor	MP Criteria: Procedure/service reviewed against Medical			
C2624	With Delivery Catheter Including All System Components	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
C2698	Brachytherapy Source Stranded Not Otherwise Specified	Unlisted: Procedure/service not specifically defined or			
02030	Per Source	classified, maybe subject to contract/clinical review.	-	-	_
C2699	Brachytherapy Source Non-Stranded Not Otherwise	Unlisted: Procedure/service not specifically defined or			
02000	Specified Per Source	classified, maybe subject to contract/clinical review.	-	-	-
	Application Of Low Cost Skin Substitute Graft To Trunk Arms	-			
C5271	Legs Total Wound Surface Area Up To 100 Sq Cm; First 25	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Sq Cm Or Less Wound Surface Area	avoid post-service review.			
	Application Of Low Cost Skin Substitute Graft To Trunk Arms				
	Legs Total Wound Surface Area Up To 100 Sq Cm; Each	MP Criteria: Procedure/service reviewed against Medical			
C5272	Additional 25 Sq Cm Wound Surface Area Or Part Thereof	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	(List Separately In Addition To Code For Primary Procedure)	avoid post-service review.			

C5273	Application Of Low Cost Skin Substitute Graft To Trunk Arms Legs Total Wound Surface Area Greater Than Or Equal To 100 Sq Cm; First 100 Sq Cm Wound Surface Area Or 1% Of Body Area Of Infants And Children	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	-	-	-
C5274	Application Of Low Cost Skin Substitute Graft To Trunk Arms Legs Total Wound Surface Area Greater Than Or Equal To 100 Sq Cm; Each Additional 100 Sq Cm Wound Surface Area Or Part Thereof Or Each Additional 1% Of Body Area Of Infants And Children Or Part Thereof (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	-	-	-
C5275	Application Of Low Cost Skin Substitute Graft To Face Scalp Eyelids Mouth Neck Ears Orbits Genitalia Hands Feet And/Or Multiple Digits Total Wound Surface Area Up To 100 Sq Cm; First 25 Sq Cm Or Less Wound Surface Area	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	-	-
C5276	Application Of Low Cost Skin Substitute Graft To Face Scalp Eyelids Mouth Neck Ears Orbits Genitalia Hands Feet And/Or Multiple Digits Total Wound Surface Area Up To 100 Sq Cm; Each Additional 25 Sq Cm Wound Surface Area Or Part Thereof (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	-	-	-
C5277	Application Of Low Cost Skin Substitute Graft To Face Scalp Eyelids Mouth Neck Ears Orbits Genitalia Hands Feet And/Or Multiple Digits Total Wound Surface Area Greater Than Or Equal To 100 Sq Cm; First 100 Sq Cm Wound Surface Area Or 1% Of Body Area Of Infants And Children	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	-	-	-
C5278	Application Of Low Cost Skin Substitute Graft To Face Scalp Eyelids Mouth Neck Ears Orbits Genitalia Hands Feet And/Or Multiple Digits Total Wound Surface Area Greater Than Or Equal To 100 Sq Cm; Each Additional 100 Sq Cm Wound Surface Area Or Part Thereof Or Each Additional 1% Of Body Area Of Infants And Children Or Part Thereof (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	-	_	_
C8900	Magnetic Resonance Angiography With Contrast Abdomen	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS.	_	-	_
C8901	Magnetic Resonance Angiography Without Contrast Abdomen	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS.	-	-	-
C8902	Magnetic Resonance Angiography Without Contrast Followed By With Contrast Abdomen	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS.	-	-	-
C8903	Magnetic Resonance Imaging With Contrast Breast; Unilateral	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS.	-	-	-

	Magnetic Resonance Imaging Without Contrast Followed By	MP Criteria: Procedures/services reviewed against Medical			
C8905	With Contrast Breast; Unilateral	Policy Criteria. Submit for Recommended Clinical Review to			
C0303	With Contrast Bleast, Offilateral	avoid post-service review by BCBS.	_	-	-
	Magnetic Resonance Imaging With Contrast Breast;	MP Criteria: Procedures/services reviewed against Medical			
C8906	Bilateral	Policy Criteria. Submit for Recommended Clinical Review to			
60300	bliatel al	avoid post-service review by BCBS.	_	-	-
	Magnetic Resonance Imaging Without Contrast Followed By				
C8908		Policy Criteria. Submit for Recommended Clinical Review to			
C8908	With Contrast Breast; Bilateral	avoid post-service review by BCBS.	_	-	-
	Magnetic Resonance Angiography With Contrast Chest	MP Criteria: Procedures/services reviewed against Medical			
C8909	(Excluding Myocardium)	Policy Criteria. Submit for Recommended Clinical Review to			
C8909	(Excluding Myocardium)	avoid post-service review by BCBS.	_	-	_
	Magnetic Resonance Angiography Without Contrast Chest	MP Criteria: Procedures/services reviewed against Medical			
C8910	(Excluding Myocardium)	Policy Criteria. Submit for Recommended Clinical Review to			
C8910	(Excluding Myocardium)	avoid post-service review by BCBS.	_	-	-
	Magnetic Resonance Angiography Without Contrast	MP Criteria: Procedures/services reviewed against Medical			
C8911	Followed By With Contrast Chest (Excluding Myocardium)	Policy Criteria. Submit for Recommended Clinical Review to			
C6911	Followed by With Contrast Chest (Excluding Myocardium)	avoid post-service review by BCBS.	_	-	-
	Magnetic Resonance Angiography With Contrast Lower	MP Criteria: Procedures/services reviewed against Medical			
C8912	Extremity	Policy Criteria. Submit for Recommended Clinical Review to			
C6512	LXtremity	avoid post-service review by BCBS.	_	-	-
	Magnetic Resonance Angiography Without Contrast Lower	MP Criteria: Procedures/services reviewed against Medical			
C8913	Extremity	Policy Criteria. Submit for Recommended Clinical Review to			
C0313	LXtremity	avoid post-service review by BCBS.	_	-	-
	Magnetic Resonance Angiography Without Contrast	MP Criteria: Procedures/services reviewed against Medical			
C8914	Followed By With Contrast Lower Extremity	Policy Criteria. Submit for Recommended Clinical Review to			
C0314	Tollowed by With Contrast Lower Extremity	avoid post-service review by BCBS.	_	-	-
	Magnetic Resonance Angiography With Contrast Pelvis	MP Criteria: Procedures/services reviewed against Medical			
C8918	Magnetic Resonance Anglography With Contrast Telvis	Policy Criteria. Submit for Recommended Clinical Review to			
C0310		avoid post-service review by BCBS.	_	-	-
	Magnetic Resonance Angiography Without Contrast Pelvis	MP Criteria: Procedures/services reviewed against Medical			
C8919	Magnetic Resonance Anglography Without Contrast Telvis	Policy Criteria. Submit for Recommended Clinical Review to			
C0313		avoid post-service review by BCBS.	_	-	_
	Magnetic Resonance Angiography Without Contrast	MP Criteria: Procedures/services reviewed against Medical			
C8920	Followed By With Contrast Pelvis	Policy Criteria. Submit for Recommended Clinical Review to			
C0320	Tollowed by With Contrast Telvis	avoid post-service review by BCBS.	_	-	-
	Magnetic Resonance Angiography With Contrast Spinal	MP Criteria: Procedures/services reviewed against Medical			
C8931	Canal And Contents	Policy Criteria. Submit for Recommended Clinical Review to			
C0331	Carlai Aria Contents	avoid post-service review by BCBS.	_	-	-
	Magnetic Resonance Angiography Without Contrast Spinal	MP Criteria: Procedures/services reviewed against Medical			
C8932	Canal And Contents	Policy Criteria. Submit for Recommended Clinical Review to			
C0332	Carlai Ariu Contents	avoid post-service review by BCBS.	_	-	_
	Magnetic Resonance Angiography Without Contrast	MP Criteria: Procedures/services reviewed against Medical			
C8933	Followed By With Contrast Spinal Canal And Contents	Policy Criteria. Submit for Recommended Clinical Review to			
20333	Tonowed by with contrast Spinal Canal And Contents	avoid post-service review by BCBS.	_	-	-
	Magnetic Resonance Angiography With Contrast Upper	MP Criteria: Procedures/services reviewed against Medical			
C8934	Extremity	Policy Criteria. Submit for Recommended Clinical Review to			
20334	LAGETHILY	avoid post-service review by BCBS.	_	-	-
		avoia post-service review by DCDS.			

	Magnetic Resonance Angiography Without Contrast Upper	MP Criteria: Procedures/services reviewed against Medical			
C8935	Extremity	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by BCBS.			
	Magnetic Resonance Angiography Without Contrast	MP Criteria: Procedures/services reviewed against Medical			
C8936	Followed By With Contrast Upper Extremity	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by BCBS.			
	Injection, tofersen, 1 mg	MP Criteria: Procedure/service reviewed against Medical			
C9157		Policy Criteria. Submit for Recommended Clinical Review to		_	
		avoid post-service review.	10/1/2023		Add effective 10/01/2023
	Injection, daxibotulinumtoxina-lanm, 1 unit	MP Criteria: Procedure/service reviewed against Medical			
C9160		Policy Criteria. Submit for Recommended Clinical Review to		L	
		avoid post-service review.	5/15/2024		Add effective 05/15/2024
	Injection, aflibercept hd, 1 mg	MP Criteria: Procedure/service reviewed against Medical			
C9161		Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review.	5/1/2024	_	Add effective 05/01/2024
	Injection Mirikizumab-Mrkz 1 Mg	MP Criteria: Procedure/service reviewed against Medical			
C9168		Policy Criteria. Submit for Recommended Clinical Review to			Effective
		avoid post-service review.	8/1/2024	_	8/1/2024
	Injection Bevacizumab 0.25 Mg	MP Criteria: Procedure/service reviewed against Medical			
	injection peruoizamas 6:25 mg	Policy Criteria. Submit for Recommended Clinical Review to			
C9257		avoid post-service review. Prior Authorization may be	_	_	_
		required per contract agreement.			
	Acellular Pericardial Tissue Matrix Of Non-Human Origin	EIU: Procedure/service not reimbursed by the Plan. Not			
C9354	(Veritas) Per Square Centimeter	subject to pre-service review. Check EIU policy, which is			
C3334	(Veritas) Fer square certificates	one of our Clinical Payment and Coding Policy (CPCP).	_	-	-
	Tendon Porous Matrix Of Cross-Linked Collagen And	EIU: Procedure/service not reimbursed by the Plan. Not			
C9356	Glycosaminoglycan Matrix (Tenoglide Tendon Protector	subject to pre-service review. Check EIU policy, which is			
C9330	Sheet) Per Square Centimeter	one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
	Dermal Substitute Native Non-Denatured Collagen Fetal	EIU: Procedure/service not reimbursed by the Plan. Not			
C9358		subject to pre-service review. Check EIU policy, which is			
C3336	Bovine Origin (Surgimend Collagen Matrix) Per 0.5 Square	one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
	Centimeters Porous Purified Collagen Matrix Bone Void Filler (Integra	MP Criteria: Procedures/services reviewed against Medical			
C9359	, ,	·			
C9359	Mozaik Osteoconductive Scaffold Putty Integra Os	Policy Criteria. Submit for Recommended Clinical Review to	_	-	_
	Osteoconductive Scaffold Putty) Per 0.5 Cc	avoid post-service review by Carelon. EIU: Procedure/service not reimbursed by the Plan. Not			
C02C0	Dermal Substitute Native Non-Denatured Collagen	· · · · · · · · · · · · · · · · · · ·			
C9360	Neonatal Bovine Origin (Surgimend Collagen Matrix) Per 0.5		_	-	-
	Square Centimeters	one of our Clinical Payment and Coding Policy (CPCP).			
	Porous Purified Collagen Matrix Bone Void Filler (Integra	MP Criteria: Procedures/services reviewed against Medical			
C9362	Mozaik Osteoconductive Scaffold Strip) Per 0.5 Cc	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by Carelon.			
	Skin Substitute Integra Meshed Bilayer Wound Matrix Per	EIU: Procedure/service not reimbursed by the Plan. Not			
C9363	Square Centimeter	subject to pre-service review. Check EIU policy, which is	_	-	-
		one of our Clinical Payment and Coding Policy (CPCP).			
	Porcine Implant Permacol Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
C9364		subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			

Unclassified Drugs Or Biologicals				
endlassined Brags of Biologicalis				
		_	-	-
	Authorization may be required per contract agreement.			
Focused Ultrasound Ablation/Therapeutic Intervention	MP Criteria: Procedure/service reviewed against Medical			
Other Than Uterine Leiomyomata With Magnetic	· ·	_	_	_
· · ·				
implant; 1 to 3 implants	•	_	_	-
Cystourethroscopy With Insertion Of Transprostatic	•			
	· ·			
implant, 1 or more implants		_	_	_
Laminotomy (Hemilaminectomy) With Decompression Of				
Nerve Root(S) Including Partial Facetectomy Foraminotomy				
And Excision Of Herniated Intervertebral Disc And Repair Of	EIU: Procedure/service not reimbursed by the Plan. Not			
Annular Defect With Implantation Of Bone Anchored	subject to pre-service review. Check EIU policy, which is	_	_	_
Annular Closure Device Including Annular Defect				
	MD Critoria: Procedure/convice reviewed against Medical			
•	-			
	· ·	_	-	-
	·			
Vessel(S); With Intravascular Lithotripsy And Transluminal				
Stent Placement(S) Includes Angioplasty Within The Same	·	-	_	-
Vessel(S) When Performed	· ·			
· · · · · · · · · · · · · · · · · · ·	MP Criteria: Procedure/service reviewed against Medical			
1.7				_
	avoid post-service review.	_	_	_
·				
, , , , , , , , , , , , , , , , , , , ,	avoid post-service review.	_	_	_
· · ·	·			
Endoscopic Ultrasound-Guided Direct Measurement Of	FILL: Procedure/service not reimbursed by the Plan Not			
Hepatic Portosystemic Pressure Gradient By Any Method	•			
(List Separately In Addition To Code For Primary Procedure)		_	_	-
Code with the Mills Locality Of Terrory Brestell	, , , ,			
implant/stent with Fixation/Anchor And Incisional Struts	· ·	_	-	-
Revascularization Endovascular Open Or Percutaneous				
·				
Includes Angioplasty Within The Same Vessel (S) When	* · · · · · · · · · · · · · · · · · · ·	-	-	-
Performed	one of our Clinical Payment and Coding Policy (CPCP).			
	Other Than Uterine Leiomyomata With Magnetic Resonance (Mr) Guidance Cystourethroscopy With Insertion Of Transprostatic Implant; 1 To 3 Implants Cystourethroscopy With Insertion Of Transprostatic Implant; 4 Or More Implants Laminotomy (Hemilaminectomy) With Decompression Of Nerve Root(S) Including Partial Facetectomy Foraminotomy And Excision Of Herniated Intervertebral Disc And Repair Of Annular Defect With Implantation Of Bone Anchored Annular Closure Device Including Annular Defect Measurement Alignment And Sizing Assessment And Image Guidance: 1 Interspace Lumbar Revascularization Endovascular Open Or Percutaneous Any Vessel(S); With Intravascular Lithotripsy Includes Angioplasty Within The Same Vessel(S) When Performed Revascularization Endovascular Open Or Percutaneous Any Vessel(S); With Intravascular Lithotripsy And Transluminal Stent Placement(S) Includes Angioplasty Within The Same Vessel(S) When Performed Revascularization Endovascular Open Or Percutaneous Any Vessel(S); With Intravascular Lithotripsy And Atherectomy Includes Angioplasty Within The Same Vessel(S) When Performed Revascularization Endovascular Open Or Percutaneous Any Vessel(S); With Intravascular Lithotripsy And Transluminal Stent Placement(S) And Atherectomy Includes Angioplasty Within The Same Vessel(S) When Performed Endoscopic Ultrasound-Guided Direct Measurement Of Hepatic Portosystemic Pressure Gradient By Any Method (List Separately In Addition To Code For Primary Procedure) Cystourethroscopy With Insertion Of Temporary Prostatic Implant/Stent With Fixation/Anchor And Incisional Struts Revascularization Endovascular Open Or Percutaneous Tibial/Peroneal Artery(Ies) With Intravascular Lithotripsy Includes Angioplasty Within The Same Vessel (S) When	Focused Ultrasound Ablation/Therapeutic Intervention Other Than Uterine Leiomyomata With Magnetic Resonance (Mr) Guidance Cystourethroscopy With Insertion Of Transprostatic Implant; 1 To 3 Implants Cystourethroscopy With Insertion Of Transprostatic Implant; 4 Or More Implants Cystourethroscopy With Insertion Of Transprostatic Implant; 4 Or More Implants Cystourethroscopy With Insertion Of Transprostatic Implant; 4 Or More Implants Cystourethroscopy With Insertion Of Transprostatic Implant; 4 Or More Implants Cystourethroscopy With Insertion Of Transprostatic Implant; 4 Or More Implants Laminotomy (Hemilaminectomy) With Decompression Of Nerve Root(S) Including Partial Facetectomy Foraminotomy And Excision Of Herniated Intervertebral Disc. And Repair Of Annular Closure Device Including Annular Defect Measurement Alignment And Sizing Assessment And Image Guidance: 1 Interspace Lumbar Revascularization Endovascular Open Or Percutaneous Any Vessel(S); With Intravascular Lithotripsy Includes Angioplasty Within The Same Vessel(S) When Performed Revascularization Endovascular Open Or Percutaneous Any Vessel(S); With Intravascular Lithotripsy And Transluminal Stent Placement(S) And Atherectomy Includes Angioplasty Within The Same Vessel(S) When Performed Revascularization Endovascular Open Or Percutaneous Any Vessel(S); With Intravascular Lithotripsy And Atherectomy Includes Angioplasty Within The Same Vessel(S) When Performed Revascularization Endovascular Open Or Percutaneous Any Vessel(S); With Intravascular Lithotripsy And Transluminal Stent Placement(S) And Atherectomy Includes Angioplasty Within The Same Vessel(S) When Performed Endoscopic Ultrasound-Guided Direct Measurement Of Hepatic Portosystemic Pressure Gradient By Any Method (List Separately In Addition To Code For Primary Procedure) Cystourethroscopy With Insertion Of Temporary Prostatic Implant/Stent With Fixation/Anchor And Incisional Struts Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Policy Criteria Pro	classified, may be subject to contract/clinical review. Prior Authorization may be required per contract agreement. Focused Ultrasound Ablation/Therapeutic Intervention Other Than Uterine Leiomyomata With Magnetic Resonance (Mr) Guidance Cystourethroscopy With Insertion Of Transprostatic Implant; 1 To 3 Implants Cystourethroscopy With Insertion Of Transprostatic Implant; 4 Or More Implants Cystourethroscopy With Insertion Of Transprostatic Implant, 4 Or More Implants Cystourethroscopy With Insertion Of Transprostatic Implant, 4 Or More Implants Cystourethroscopy With Insertion Of Transprostatic Implant, 4 Or More Implants Cystourethroscopy With Insertion Of Transprostatic Implant, 4 Or More Implants Laminotomy (Hemilaminectomy) With Decompression Of Nerve Root(S) Including Partial Facetectomy Foraminotomy And Excision of Herniated Intervertebral Disc And Repair Of Annular Defect With Implantation Of Bone Anchored Annular Closure Device Including Annular Defect Measurement Alignment And Sizing Assessment And Image Guidance: Linerspace Lumbar Revascularization Endovascular Open Or Percutaneous Any Vesse(S); With Intravascular Lithotripsy And Translumnial Stent Placement(S) Includes Angioplasty Within The Same Vesse(S) When Performed Revascularization Endovascular Open Or Percutaneous Any Vesse(S); With Intravascular Lithotripsy And Atherectomy Includes Angioplasty Within The Same Vesse(S) When Performed Revascularization Endovascular Open Or Percutaneous Any Vesse(S); With Intravascular Lithotripsy And Atherectomy Includes Angioplasty Within The Same Vesse(S) When Performed Endoscopic Ultrasound-Guided Direct Measurement Of Hepatic Portoxystemic Pressure Gradient By Any Method (List Separately In Addition To Code For Primary Procedure) Endoscopic Ultrasound-Guided Direct Measurement Of Hepatic Portoxystemic Pressure Gradient By Any Method (List Separately In Addition To Code For Primary Procedure) Endoscopic Ultrasound-Guided Direct Measurement Of Hepatic Portoxystemic Pressure Gradient By Any Method (L	Consider Procedure/Service of Specialized More Procedure/Service review Prior Authorization may be required per contract Agreement. Focused Ultrasound Ablation/Therapeutic Intervention Other Than Uterine Leiomyomata With Magnetic Resonance (Mr) Guidance Resonance (Mr) Guidance Cystourethroscopy With Insertion Of Transprostatic Implant; 3 To 3 Implants Cystourethroscopy With Insertion Of Transprostatic Implant; 4 Or More Implants Cystourethroscopy With Insertion Of Transprostatic Implant; 4 Or More Implants Cystourethroscopy With Insertion Of Transprostatic Implant; 4 Or More Implants Laminotomy (Hemilaminectomy) With Decompression Of Nerve Root(S) Including Partial Facetectomy Foraminotomy And Excision Of Hernitade thereverberbal Disc And Repair Of Annular Defect With Implantation Of Bone Anchored Annular Coluzer Device Including Annular Defect Measurement Alignment And Sizing Assessment And Image Guidance: Linterspace Lumbar: Revascularization Endovascular Open Or Percutaneous Any Vessel(S) With Intravascular Linterhorsy And Linterhorsy Includes Angioplasty Within The Same Vessel(S) When Performed Revascularization Endovascular Open Or Percutaneous Any Vessel(S): With Intravascular Linterhorsy And Excision of Recommended Clinical Review to avoid post-service review. And Procedure/Service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service reviewed. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended C

		I			
	Revascularization Endovascular Open Or Percutaneous	EIU: Procedure/service not reimbursed by the Plan. Not			
C9773	Tibial/Peroneal Artery(les); With Intravascular Lithotripsy	subject to pre-service review. Check EIU policy, which is	_	_	_
	And Transluminal Stent Placement(S) Includes Angioplasty Within The Same Vessel(S) When Performed	one of our Clinical Payment and Coding Policy (CPCP).			
	Revascularization Endovascular Open Or Percutaneous				
	Tibial/Peroneal Artery(les); With Intravascular Lithotripsy	EIU: Procedure/service not reimbursed by the Plan. Not			
C9774	And Atherectomy Includes Angioplasty Within The Same	subject to pre-service review. Check EIU policy, which is	_	_	_
	Vessel (S) When Performed	one of our Clinical Payment and Coding Policy (CPCP).			
	Revascularization Endovascular Open Or Percutaneous				
	Tibial/Peroneal Artery(les); With Intravascular Lithotripsy	EIU: Procedure/service not reimbursed by the Plan. Not			
C9775	And Transluminal Stent Placement(S) And Atherectomy	subject to pre-service review. Check EIU policy, which is	_	_	_
	Includes Angioplasty Within The Same Vessel (S) When	one of our Clinical Payment and Coding Policy (CPCP).			
	Performed				
	Esophageal Mucosal Integrity Testing By Electrical	EIU: Procedure/service not reimbursed by the Plan. Not			
C9777	Impedance Transoral Includes Esophagoscopy Or	subject to pre-service review. Check EIU policy, which is	_	_	_
	Esophagogastroduodenoscopy	one of our Clinical Payment and Coding Policy (CPCP).			
	Blinded Procedure For New York Heart Association (Nyha)				
	Class Ii Or Iii Heart Failure Or Canadian Cardiovascular				
	Society (Ccs) Class Iii Or Iv Chronic Refractory Angina;				
	Transcatheter Intramyocardial Transplantation Of				
	Autologous Bone Marrow Cells (E.G. Mononuclear) Or	MP Criteria: Procedure/service reviewed against Medical			
C9782	Placebo Control Autologous Bone Marrow Harvesting And	Policy Criteria. Submit for Recommended Clinical Review to		_	
	Preparation For Transplantation Left Heart Catheterization	avoid post-service review.			
	Including Ventriculography All Laboratory Services And All				
	Imaging With Or Without Guidance (E.G. Transthoracic				
	Echocardiography Ultrasound Fluoroscopy) Performed In				
	An Approved Investigational Device Exemption (Ide) Study		2/1/2024		Add effective 02/1/2024
	Gastric Restrictive Procedure Endoscopic Sleeve	FILL December / comition and university would be the Disc. Not			
C0704	Gastroplasty With Esophagogastroduodenoscopy And	EIU: Procedure/service not reimbursed by the Plan. Not			
C9784	Intraluminal Tube Insertion If Performed Including All	subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
	System And Tissue Anchoring Components	one of our clinical Payment and Coding Policy (CPCP).			
	Endoscopic Outlet Reduction Gastric Pouch Application	EIU: Procedure/service not reimbursed by the Plan. Not			
C9785	With Endoscopy And Intraluminal Tube Insertion If	subject to pre-service review. Check EIU policy, which is			
63763	Performed Including All System And Tissue Anchoring	one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
	Components	, , , ,			
	Echocardiography Image Post Processing For Computer	MP Criteria: Procedure/service reviewed against Medical			
C9786	Aided Detection Of Heart Failure With Preserved Ejection	Policy Criteria. Submit for Recommended Clinical Review to	_	_	-
	Fraction Including Interpretation And Report	avoid post-service review.			
C0702	3D Predictive Model Generation For Pre-Planning Of A	MP Criteria: Procedure/service reviewed against Medical			Effective
C9793	Cardiac Procedure Using Data From Cardiac Computed	Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2024	_	8/1/2024
	Tomographic Angiography With Report Repair Of Enterocutaneous Fistula Small Intestine Or Colon	EIU: Procedure/service not reimbursed by the Plan. Not	0/ 1/ 2024		0/ 1/ 2024
C9796	(Excluding Anorectal Fistula) With Plug (E.G. Porcine Small	subject to pre-service review. Check EIU policy, which is			
63730	Intestine Submucosa [Sis])	one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	-	Add effective 07/01/2024
	Intrestine additional [313])	one of our chilical rayment and county rolley (CPCP).	771/2024		/ Ida Circuive 0//01/2024

	Parair Of Fatarantanana Fistula Casall Intestina On	NAD Criterias Durandous / sourcissous description			
		MP Criteria: Procedure/service reviewed against			
C9796	Colon (Excluding Anorectal Fistula) With Plug (E.G.	Medical Policy Criteria. Submit for Recommended			Add effective 04/01/2024
	Porcine Small Intestine Submucosa [Sis])	Clinical Review to avoid post-service review.	4/1/2024	6/30/2024	Retire effective 06/30/2024
	Repair Of Enterocutaneous Fistula Small Intestine Or	EIU: Procedure/service not reimbursed by the Plan.			
	Colon (Excluding Anorectal Fistula) With Plug (E.G.	Not subject to pre-service review. Check EIU policy,			
C9796	Porcine Small Intestine Submucosa [Sis])	which is one of our Clinical Payment and Coding		_	
	To tome small intestine submucosa [515])	Policy (CPCP).	7/1/2024		Add effective 07/01/2024
	Radiolabeled Product Provided During A Hospital Inpatient	Unlisted: Procedure/service not specifically defined or	7/1/2024		71dd C11CC11VC 0770172024
C9898		classified, maybe subject to contract/clinical review.	_	_	_
	Stay Implanted Prosthetic Device Payable Only For Inpatients	Unlisted: Procedure/service not specifically defined or			
C9899	Who Do Not Have Inpatient Coverage	classified, maybe subject to contract/clinical review.	_	_	_
	Unspecified Diagnostic Procedure By Report	Unlisted: Procedure/service not specifically defined or			
D0999	onspecified Bidghostic Procedure By Report	classified, maybe subject to contract/clinical review.	_	_	_
	Astrazeneca Covid-19 Vaccine Administration – First Dose	Non Covered: Procedure/service not covered by the Plan.			
D1705	7 Strazeneca covia 15 Vaccine Naministration 1115t Bose	Not subject to pre-service review.	_	_	_
	Astrazeneca Covid-19 Vaccine Administration – Second Dose				
D1706	7 St. azeriesa seria za rasonie raministration sessina sess	Not subject to pre-service review.	_	_	_
	Unspecified Preventive Procedure By Report	Unlisted: Procedure/service not specifically defined or			
D1999	, ,,,,,	classified, maybe subject to contract/clinical review.	_	_	_
	Unspecified Restorative Procedure By Report	Unlisted: Procedure/service not specifically defined or			
D2999		classified, maybe subject to contract/clinical review.	_	_	_
20110	Apicoectomy - Anterior	Non Covered: Procedure/service not covered by the Plan.			
D3410		Not subject to pre-service review.	-	-	-
D3999	Unspecified Endodontic Procedure By Report	Unlisted: Procedure/service not specifically defined or			
D3999		classified, maybe subject to contract/clinical review.	-	-	_
D4999	Unspecified Periodontal Procedure By Report	Unlisted: Procedure/service not specifically defined or			
D4333		classified, maybe subject to contract/clinical review.	_	-	_
D5899	Unspecified Removable Prosthodontic Procedure By Report	Unlisted: Procedure/service not specifically defined or			
D3033		classified, maybe subject to contract/clinical review.	-	-	_
D5999	Unspecified Maxillofacial Prosthesis By Report	Unlisted: Procedure/service not specifically defined or			
D3333		classified, maybe subject to contract/clinical review.	-	-	-
D6199	Unspecified Implant Procedure By Report	Unlisted: Procedure/service not specifically defined or			
50155		classified, maybe subject to contract/clinical review.	-	-	-
D6999	Unspecified Fixed Prosthodontic Procedure By Report	Unlisted: Procedure/service not specifically defined or			
		classified, maybe subject to contract/clinical review.	_	-	_
	Extraction Erupted Tooth Requiring Removal Of Bone	Non Covered: Procedure/service not covered by the Plan.			
D7210	And/Or Sectioning Of Tooth And Including Elevation Of	Not subject to pre-service review.	_	_	_
	Mucoperiosteal Flap If Indicated				
D7220	Removal Of Impacted Tooth - Soft Tissue	Non Covered: Procedure/service not covered by the Plan.			_
	Developed Of Invested Teath Devicelly Devel	Not subject to pre-service review.			
D7230	Removal Of Impacted Tooth - Partially Bony	Non Covered: Procedure/service not covered by the Plan.		_	_
	Unenceified Oral Surgery Procedure By Depart	Not subject to pre-service review. Unlisted: Procedure/service not specifically defined or			
D7999	Unspecified Oral Surgery Procedure By Report	· · · · · · · · · · · · · · · · · · ·	_	_	_
	Removable Appliance Therapy	classified, maybe subject to contract/clinical review. Non Covered: Procedure/service not covered by the Plan.			
D8210	nemovable Appliance Therapy	Not subject to pre-service review.	_	_	_
		INOU SUBJECT TO PIE-SELVICE LEVIEW.			

	Fixed Appliance Therapy	Non Covered: Procedure/service not covered by the Plan.			
D8220	Плец Арриансе Петару	Not subject to pre-service review.	_	_	_
	Unspecified Orthodontic Procedure By Report	Unlisted: Procedure/service not specifically defined or			
D8999	onspecified orthodolitic Procedure by Report	classified, maybe subject to contract/clinical review.	_	_	_
	Unspecified Adjunctive Procedure By Report	Unlisted: Procedure/service not specifically defined or			
D9999	onspecified Adjunctive Procedure by Report	classified, maybe subject to contract/clinical review.	_	_	_
	Powered Pressure Reducing Underlay/Pad Alternating With				
E0183	5 "	Policy Criteria. Submit for Recommended Clinical Review to			
EU183	Pump Includes Heavy Duty	•	-	-	-
	Floring Hook Dod Chandend	avoid post-service review. Non Covered: Procedure/service not covered by the Plan.			
E0210	Electric Heat Pad Standard	i de la companya de	_	_	_
	Mark Contact and Dad Milk David	Not subject to pre-service review.			
E0217	Water Circulating Heat Pad With Pump	Non Covered: Procedure/service not covered by the Plan.	_		_
		Not subject to pre-service review.			
E0218	Fluid Circulating Cold Pad With Pump Any Type	Non Covered: Procedure/service not covered by the Plan.			
		Not subject to pre-service review.			
	Infrared Heating Pad System	EIU: Procedure/service not reimbursed by the Plan. Not			
E0221		subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	, , ,	EIU: Procedure/service not reimbursed by the Plan. Not			
E0231	Unit Ac Adapter And Power Cord) For Use With Warming	subject to pre-service review. Check EIU policy, which is	_	_	_
	Card And Wound Cover	one of our Clinical Payment and Coding Policy (CPCP).			
	Warming Card For Use With The Non Contact Wound	EIU: Procedure/service not reimbursed by the Plan. Not			
E0232	Warming Device And Non Contact Wound Warming Wound	subject to pre-service review. Check EIU policy, which is	_	_	_
	Cover	one of our Clinical Payment and Coding Policy (CPCP).			
E0236	Pump For Water Circulating Pad	Non Covered: Procedure/service not covered by the Plan.			
L0230		Not subject to pre-service review.	-	-	_
E0240	Bath/Shower Chair With Or Without Wheels Any Size	Non Covered: Procedure/service not covered by the Plan.			
L0240		Not subject to pre-service review.	-	-	_
E0241	Bath Tub Wall Rail Each	Non Covered: Procedure/service not covered by the Plan.			
EU241		Not subject to pre-service review.	_	_	_
F0242	Bath Tub Rail Floor Base	Non Covered: Procedure/service not covered by the Plan.			
E0242		Not subject to pre-service review.	_	-	-
50242	Toilet Rail Each	Non Covered: Procedure/service not covered by the Plan.			
E0243		Not subject to pre-service review.	_	-	_
50244	Raised Toilet Seat	Non Covered: Procedure/service not covered by the Plan.			
E0244		Not subject to pre-service review.	_	-	_
	Tub Stool Or Bench	Non Covered: Procedure/service not covered by the Plan.			
E0245		Not subject to pre-service review.	_	_	_
	Transfer Tub Rail Attachment	Non Covered: Procedure/service not covered by the Plan.			
E0246		Not subject to pre-service review.	_	_	_
	Transfer Bench For Tub Or Toilet With Or Without Commode				
E0247	Opening	Not subject to pre-service review.	_	_	_
	Transfer Bench Heavy Duty For Tub Or Toilet With Or	Non Covered: Procedure/service not covered by the Plan.			
E0248	Without Commode Opening	Not subject to pre-service review.	_	_	_
	Bed Board	Non Covered: Procedure/service not covered by the Plan.			
E0273	Dea Douit	Not subject to pre-service review.	_	_	_
		ivot subject to pre-service review.			

	Over-Bed Table	Non Covered: Procedure/service not covered by the Plan.			
E0274	over bed rubic	Not subject to pre-service review.	_	_	_
	Pediatric Crib Hospital Grade Fully Enclosed With Or	MP Criteria: Procedure/service reviewed against Medical			
E0300	Without Top Enclosure	Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review.	_		_
	Bed Accessory: Board Table Or Support Device Any Type	Non Covered: Procedure/service not covered by the Plan.			
E0315	'''	Not subject to pre-service review.	-	-	-
	Safety Enclosure Frame/Canopy For Use With Hospital Bed	MP Criteria: Procedure/service reviewed against Medical			
E0316	Any Type	Policy Criteria. Submit for Recommended Clinical Review to	_		
	<i>'</i> ''	avoid post-service review.			
50446	Topical Oxygen Delivery System Not Otherwise Specified	Unlisted: Procedure/service not specifically defined or			
E0446	Includes All Supplies And Accessories	classified, maybe subject to contract/clinical review.	_	-	-
	Oral Device/Appliance Used To Reduce Upper Airway	MP Criteria: Procedure/service reviewed against Medical			
50.405	Collapsibility Adjustable Or Non-Adjustable Prefabricated	Policy Criteria. Submit for Recommended Clinical Review to			
E0485	Includes Fitting And Adjustment	avoid post-service review. Prior Authorization may be	_	-	-
	,	required per contract agreement.			
	Oral Device/Appliance Used To Reduce Upper Airway	MP Criteria: Procedure/service reviewed against Medical			
	Collapsibility Adjustable Or Non-Adjustable Custom	Policy Criteria. Submit for Recommended Clinical Review to			
E0486	Fabricated Includes Fitting And Adjustment	avoid post-service review. Prior Authorization may be	_	_	_
	, , , , , , , , , , , , , , , , , , , ,	required per contract agreement.			
	Spirometer Electronic Includes All Accessories	EIU: Procedure/service not reimbursed by the Plan. Not			
E0487		subject to pre-service review. Check EIU policy, which is			
		one of our Clinical Payment and Coding Policy (CPCP).	_		
	Power Source And Control Electronics Unit For Oral				
	Device/Appliance For Neuromuscular Electrical Stimulation	EIU: Procedure/service not reimbursed by the Plan. Not			
E0490	Of The Tongue Muscle Controlled By Hardware Remote	subject to pre-service review. Check EIU policy, which is	_	-	_
	,	one of our Clinical Payment and Coding Policy (CPCP).			
	Oral Device/Appliance For Neuromuscular Electrical	FUL Duncadous / carries and unicaboused booths Dies. Not			
F0.401	Stimulation Of The Tongue Muscle Used In Conjunction	EIU: Procedure/service not reimbursed by the Plan. Not			
E0491	With The Power Source And Control Electronics Unit	subject to pre-service review. Check EIU policy, which is	-	-	-
	Controlled By Hardware Remote 90-Day Supply	one of our Clinical Payment and Coding Policy (CPCP).			
	Power Source And Control Electronics Unit For Oral	NAD Criteria: Due and una /ann inc una incured anningt NA adical			
E0492	Device/Appliance For Neuromuscular Electrical Stimulation	MP Criteria: Procedure/service reviewed against Medical			
E0492	Of The Tongue Muscle Controlled By Phone Application	Policy Criteria. Submit for Recommended Clinical Review to		-	
		avoid post-service review.	3/1/2024		Add effective 03/01/2024
	Oral Device/Appliance For Neuromuscular Electrical	NAD Critoria, Dragoduro (consist antiqued antiqued antiqued			
F0403	Stimulation Of The Tongue Muscle Used In Conjunction	MP Criteria: Procedure/service reviewed against Medical			
E0493	With The Power Source And Control Electronics Unit	Policy Criteria. Submit for Recommended Clinical Review to		-	
	Controlled By Phone Application 90-Day Supply	avoid post-service review.	3/1/2024		Add effective 03/01/2024
	Electronic Positional Obstructive Sleep Apnea Treatment	MP Criteria: Procedure/service reviewed against Medical			
E0530	With Sensor Includes All Components And Accessories Any	Policy Criteria. Submit for Recommended Clinical Review to		L	
	Туре	avoid post-service review.	3/1/2024		Add effective 03/01/2024
	Implantable Cardiac Event Recorder With Memory Activator				
E0616	And Programmer	Policy Criteria. Submit for Recommended Clinical Review to	_	L	L
	-	avoid post-service review.			
		The state of the s			

	External Defibrillator With Integrated Electrocardiogram	MP Criteria: Procedure/service reviewed against Medical			
E0617	Analysis	Policy Criteria. Submit for Recommended Clinical Review to			Effective
20017	Allalysis	avoid post-service review.	5/15/2024	_	5/15/2024
	Patient Lift Bathroom Or Toilet Not Otherwise Classified	Unlisted: Procedure/service not specifically defined or	3/13/2021		37 137 202 1
E0625	Tatient Life Bathloom of Tollet Not Otherwise classified	classified, maybe subject to contract/clinical review.	_	_	_
	Patient Lift Electric With Seat Or Sling	MP Criteria: Procedure/service reviewed against Medical			
E0635	Tatient Life Electric With Scat of Sinig	Policy Criteria. Submit for Recommended Clinical Review to			
20000		avoid post-service review.	_	_	-
	Combination Sit To Stand Frame/Table System Any Size	MP Criteria: Procedure/service reviewed against Medical			
E0637	Including Pediatric With Seat Lift Feature With Or Without	Policy Criteria. Submit for Recommended Clinical Review to			
	Wheels	avoid post-service review.	_	_	-
	Standing Frame/Table System One Position (E.G. Upright	MP Criteria: Procedure/service reviewed against Medical			
E0638	Supine Or Prone Stander) Any Size Including Pediatric With	Policy Criteria. Submit for Recommended Clinical Review to			
	Or Without Wheels	avoid post-service review.	_	-	_
	Standing Frame/Table System Multi-Position (E.G. Three-	MP Criteria: Procedure/service reviewed against Medical			
E0641		Policy Criteria. Submit for Recommended Clinical Review to			
	Wheels	avoid post-service review.	_	Ī	_
	Standing Frame/Table System Mobile (Dynamic Stander)	MP Criteria: Procedure/service reviewed against Medical			
E0642	Any Size Including Pediatric	Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review.			_
	Pneumatic Compressor Non-Segmental Home Model	MP Criteria: Procedure/service reviewed against Medical			
E0650		Policy Criteria. Submit for Recommended Clinical Review to	_		_
		avoid post-service review.			
	Pneumatic Compressor Segmental Home Model Without	MP Criteria: Procedure/service reviewed against Medical			
E0651	Calibrated Gradient Pressure	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Pneumatic Compressor Segmental Home Model With	MP Criteria: Procedure/service reviewed against Medical			
E0652	Calibrated Gradient Pressure	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Non-Segmental Pneumatic Appliance For Use With	MP Criteria: Procedure/service reviewed against Medical			
E0655	Pneumatic Compressor Half Arm	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Segmental Pneumatic Appliance For Use With Pneumatic	MP Criteria: Procedure/service reviewed against Medical			
E0656	Compressor Trunk	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Segmental Pneumatic Appliance For Use With Pneumatic	MP Criteria: Procedure/service reviewed against Medical			
E0657	Compressor Chest	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Non-Segmental Pneumatic Appliance For Use With	MP Criteria: Procedure/service reviewed against Medical			
E0660	Pneumatic Compressor Full Leg	Policy Criteria. Submit for Recommended Clinical Review to	_	-	_
		avoid post-service review.			
50555	Non-Segmental Pneumatic Appliance For Use With	MP Criteria: Procedure/service reviewed against Medical			
E0665	Pneumatic Compressor Full Arm	Policy Criteria. Submit for Recommended Clinical Review to	-	-	-
		avoid post-service review.			
50555	Non-Segmental Pneumatic Appliance For Use With	MP Criteria: Procedure/service reviewed against Medical			
E0666	Pneumatic Compressor Half Leg	Policy Criteria. Submit for Recommended Clinical Review to	_	-	-
		avoid post-service review.			

	Commental December Appliance For Use With December	MP Criteria: Procedure/service reviewed against Medical		1	
50667	Segmental Pneumatic Appliance For Use With Pneumatic				
E0667	Compressor Full Leg	Policy Criteria. Submit for Recommended Clinical Review to	_	-	_
		avoid post-service review.			
	Segmental Pneumatic Appliance For Use With Pneumatic	MP Criteria: Procedure/service reviewed against Medical			
E0668	Compressor Full Arm	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Segmental Pneumatic Appliance For Use With Pneumatic	MP Criteria: Procedure/service reviewed against Medical			
E0669	Compressor Half Leg	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Segmental Pneumatic Appliance For Use With Pneumatic	MP Criteria: Procedure/service reviewed against Medical			
E0670	Compressor Integrated 2 Full Legs And Trunk	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Segmental Gradient Pressure Pneumatic Appliance Full Leg	MP Criteria: Procedure/service reviewed against Medical			
E0671		Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review.			
	Segmental Gradient Pressure Pneumatic Appliance Full Arm				
E0672		Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review.	_	_	_
	Segmental Gradient Pressure Pneumatic Appliance Half Leg				
E0673	Segmental Gradient Fessare Friedmatic Appliance Trail Eeg	Policy Criteria. Submit for Recommended Clinical Review to			
20073		avoid post-service review.	-	-	_
	Pneumatic Compression Device High Pressure Rapid	EIU: Procedure/service not reimbursed by the Plan. Not			
E067E	Inflation/Deflation Cycle For Arterial Insufficiency	subject to pre-service review. Check EIU policy, which is			
E0675			_	-	_
	(Unilateral Or Bilateral System)	one of our Clinical Payment and Coding Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical			
	Intermittent Limb Compression Device (Includes All	-			
	Accessories) Not Otherwise Specified	Policy Criteria. Submit for Recommended Clinical Review to			
E0676		avoid post-service review.			
		Unlisted or Undefined: Procedures/services not specifically			
		defined or classified, maybe subject to contract/clinical			
		review.			
	Non-Pneumatic Sequential Compression Garment Trunk	MP Criteria: Procedure/service reviewed against Medical			
E0677		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Non-Pneumatic Sequential Compression Garment Full Leg	MP Criteria: Procedure/service reviewed against Medical			
E0678		Policy Criteria. Submit for Recommended Clinical Review to		_	
		avoid post-service review.	2/15/2024		Add effective 02/15/2024
	Non-Pneumatic Sequential Compression Garment Half Leg	MP Criteria: Procedure/service reviewed against Medical			
E0679		Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review.	2/15/2024		Add effective 02/15/2024
	Non-Pneumatic Compression Controller With Sequential	MP Criteria: Procedure/service reviewed against Medical			
E0680	Calibrated Gradient Pressure	Policy Criteria. Submit for Recommended Clinical Review to			
	23.10.0000 0.000.0000	avoid post-service review.	2/15/2024	_	Add effective 02/15/2024
	Non-Pneumatic Compression Controller Without Calibrated	MP Criteria: Procedure/service reviewed against Medical	,, ·		
E0681	Gradient Pressure	Policy Criteria. Submit for Recommended Clinical Review to			
20001	Gradient Fressure	· ·	2/15/2024	-	Add effective 02/15/2024
		avoid post-service review.	41 TO 1 CO 24		Add Ellective 02/13/2024

	Non-Pneumatic Sequential Compression Garment Full Arm	MP Criteria: Procedure/service reviewed against Medical			
E0682	,	Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review.	2/15/2024	-	Add effective 02/15/2024
	Ultraviolet Light Therapy System Includes Bulbs/Lamps	MP Criteria: Procedure/service reviewed against Medical			
E0691	Timer And Eye Protection; Treatment Area 2 Square Feet Or	Policy Criteria. Submit for Recommended Clinical Review to			
	Less	avoid post-service review.	_	_	_
	Ultraviolet Light Therapy System Panel Includes	MP Criteria: Procedure/service reviewed against Medical			
E0692	Bulbs/Lamps Timer And Eye Protection 4 Foot Panel	Policy Criteria. Submit for Recommended Clinical Review to			
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	avoid post-service review.	_	_	_
	Ultraviolet Light Therapy System Panel Includes	MP Criteria: Procedure/service reviewed against Medical			
E0693	Bulbs/Lamps Timer And Eye Protection 6 Foot Panel	Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review.			
	Ultraviolet Multidirectional Light Therapy System In 6 Foot	MP Criteria: Procedure/service reviewed against Medical			
E0694	Cabinet Includes Bulbs/Lamps Timer And Eye Protection	Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review.			
	Cranial Electrotherapy Stimulation (Ces) System Any Type	EIU: Procedure/service not reimbursed by the Plan. Not			
E0732		subject to pre-service review. Check EIU policy, which is			
		one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	_	Add effective 05/15/2024
	Cranial Electrotherapy Stimulation (Ces) System Any Type	MP Criteria: Procedure/service reviewed against Medical			
E0732		Policy Criteria. Submit for Recommended Clinical Review to			Add effective 02/15/2024
		avoid post-service review.	2/15/2024	5/14/202	4 Retire effective 05/14/2024
	Transcutaneous Electrical Nerve Stimulator For Electrical	MP Criteria: Procedure/service reviewed against Medical			
E0733	Stimulation Of The Trigeminal Nerve	Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review.	2/15/2024	_	Add effective 02/15/2024
	External Upper Limb Tremor Stimulator Of The Peripheral	EIU: Procedure/service not reimbursed by the Plan. Not			
E0734	Nerves Of The Wrist	subject to pre-service review. Check EIU policy, which is			
		one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024		Add effective 05/15/2024
	External Upper Limb Tremor Stimulator Of The Peripheral	MP Criteria: Procedure/service reviewed against Medical			
E0734	Nerves Of The Wrist	Policy Criteria. Submit for Recommended Clinical Review to			Add effective 02/15/2024
		avoid post-service review.	2/15/2024	5/14/202	Retire effective 05/14/2024
	Non-Invasive Vagus Nerve Stimulator	MP Criteria: Procedure/service reviewed against Medical			
E0735		Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review.	2/15/2024	_	Add effective 02/15/2024
	Non-Implanted Pelvic Floor Electrical Stimulator Complete	EIU: Procedure/service not reimbursed by the Plan. Not			
E0740	System	subject to pre-service review. Check EIU policy, which is			
		one of our Clinical Payment and Coding Policy (CPCP).			
	Neuromuscular Stimulator For Scoliosis	MP Criteria: Procedure/service reviewed against			
E0744		Medical Policy Criteria. Submit for Recommended			
20711		·	4/1/2024	-	Add effective 04/01/2024
	Neuronaulas Chimadatas Electronia Check Unit	· · · · · · · · · · · · · · · · · · ·	4/1/2024		Add Circuit 04/01/2024
E074E	Neuromuscular Stimulator Electronic Shock Unit	MP Criteria: Procedures/services reviewed against Medical			
E0745		Policy Criteria. Submit for Recommended Clinical Review to	-	-	-
	Floatromyography (Fma) Bisfoodlast, Davids	avoid post-service review by BCBS.			+
50746	Electromyography (Emg) Biofeedback Device	MP Criteria: Procedure/service reviewed against Medical			
E0746		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			

	Osteogenesis Stimulator Electrical Non-Invasive Other	MP Criteria: Procedure/service reviewed against Medical			
E0747	Than Spinal Applications	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Osteogenesis Stimulator Electrical Non-Invasive Spinal	MP Criteria: Procedures/services reviewed against Medical			
E0748	Applications	Policy Criteria. Submit for Recommended Clinical Review to			
20748	Applications	· ·	_	_	-
		avoid post-service review by Carelon.			
	Osteogenesis Stimulator Electrical Surgically Implanted	MP Criteria: Procedures/services reviewed against Medical			
E0749		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by Carelon.			
	Osteogenesis Stimulator Low Intensity Ultrasound Non-	MP Criteria: Procedure/service reviewed against Medical			
E0760	Invasive	Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review.	_		_
	Non-Thermal Pulsed High Frequency Radiowaves High Peak				
E0761	Power Electromagnetic Energy Treatment Device	Policy Criteria. Submit for Recommended Clinical Review to			
20701	rower Electromagnetic Energy Treatment Device	· ·	_	-	-
	Towns to the Electrical Initial Cities Initial Decision Contact	avoid post-service review.			
	Transcutaneous Electrical Joint Stimulation Device System	EIU: Procedure/service not reimbursed by the Plan. Not			
E0762	Includes All Accessories	subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Functional Neuromuscular Stimulation Transcutaneous				
	Stimulation Of Sequential Muscle Groups Of Ambulation	EIU: Procedure/service not reimbursed by the Plan. Not			
E0764	With Computer Control Used For Walking By Spinal Cord	subject to pre-service review. Check EIU policy, which is			
	Injured Entire System After Completion Of Training	one of our Clinical Payment and Coding Policy (CPCP).	_		_
	Program	one of our chimear ayment and country to day (er er).			
	Fda Approved Nerve Stimulator With Replaceable Batteries	MP Criteria: Procedures/services reviewed against Medical			
F07CF		·			
E0765	For Treatment Of Nausea And Vomiting	Policy Criteria. Submit for Recommended Clinical Review to	_	-	-
		avoid post-service review by BCBS.			
	Electrical Stimulation Device Used For Cancer Treatment	MP Criteria: Procedure/service reviewed against Medical			
E0766	Includes All Accessories Any Type	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Electrical Stimulation Or Electromagnetic Wound Treatment	EIU: Procedure/service not reimbursed by the Plan. Not			
E0769	Device Not Otherwise Classified	subject to pre-service review. Check EIU policy, which is			
	Service Hot Gard Historians	one of our Clinical Payment and Coding Policy (CPCP).	_		-
	Functional Electrical Stimulator Transcutaneous Stimulation	MP Criteria: Procedure/service reviewed against Medical			
		Policy Criteria. Submit for Recommended Clinical Review to			
	Of Nerve And/Or Muscle Groups Any Type Complete	· ·			
E0770	System Not Otherwise Specified	avoid post-service review.			
		Unlisted or Undefined: Procedures/services not specifically	_	_	_
		defined or classified, maybe subject to contract/clinical			
		review.			
	Ambulatory Traction Device All Types Each	EIU: Procedure/service not reimbursed by the Plan. Not			
E0830	· ·	subject to pre-service review. Check EIU policy, which is			
		one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
	Traction Frame Attached To Headboard Cervical Traction	EIU: Procedure/service not reimbursed by the Plan. Not			
E0840	Traction Traine Attached To Headboard Cervical Haction	subject to pre-service review. Check EIU policy, which is			
LU04U		* * * * * * * * * * * * * * * * * * * *	-	-	-
		one of our Clinical Payment and Coding Policy (CPCP).			
	Traction Equipment Cervical Free-Standing Stand/Frame	EIU: Procedure/service not reimbursed by the Plan. Not			
E0849	Pneumatic Applying Traction Force To Other Than Mandible	subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			

	Traction Stand Free Standing Cervical Traction	EIU: Procedure/service not reimbursed by the Plan. Not		
E0850		subject to pre-service review. Check EIU policy, which is	_	_
		one of our Clinical Payment and Coding Policy (CPCP).		
	Cervical Traction Equipment Not Requiring Additional Stand	EIU: Procedure/service not reimbursed by the Plan. Not		
E0855	Or Frame	subject to pre-service review. Check EIU policy, which is	_	_
		one of our Clinical Payment and Coding Policy (CPCP).		
	Cervical Traction Device With Inflatable Air Bladder(S)	EIU: Procedure/service not reimbursed by the Plan. Not		
E0856		subject to pre-service review. Check EIU policy, which is	_	_
		one of our Clinical Payment and Coding Policy (CPCP).		
	Traction Equipment Overdoor Cervical	EIU: Procedure/service not reimbursed by the Plan. Not		
E0860		subject to pre-service review. Check EIU policy, which is	_	_
		one of our Clinical Payment and Coding Policy (CPCP).		
	Traction Frame Attached To Footboard Pelvic Traction	EIU: Procedure/service not reimbursed by the Plan. Not		
E0890		subject to pre-service review. Check EIU policy, which is	_	_
		one of our Clinical Payment and Coding Policy (CPCP).		
	Continuous Passive Motion Exercise Device For Use Other	EIU: Procedure/service not reimbursed by the Plan. Not		
E0936	Than Knee	subject to pre-service review. Check EIU policy, which is		_
		one of our Clinical Payment and Coding Policy (CPCP).		
	Cervical Head Harness/Halter	EIU: Procedure/service not reimbursed by the Plan. Not		
E0942		subject to pre-service review. Check EIU policy, which is		
		one of our Clinical Payment and Coding Policy (CPCP).		
	Pelvic Belt/Harness/Boot	EIU: Procedure/service not reimbursed by the Plan. Not		
E0944		subject to pre-service review. Check EIU policy, which is		
		one of our Clinical Payment and Coding Policy (CPCP).	_	_
	Wheelchair Accessory Seat Lift Mechanism	MP Criteria: Procedure/service reviewed against Medical		
E0985	·	Policy Criteria. Submit for Recommended Clinical Review to		
		avoid post-service review.		
	Manual Wheelchair Accessory Push-Rim Activated Power	MP Criteria: Procedure/service reviewed against Medical		
E0986	Assist System	Policy Criteria. Submit for Recommended Clinical Review to		
	,	avoid post-service review.	_	_
	Wheelchair Accessory Power Seating System Tilt Only	MP Criteria: Procedure/service reviewed against Medical		
E1002	, , , , , ,	Policy Criteria. Submit for Recommended Clinical Review to		
		avoid post-service review.	_	_
	Wheelchair Accessory Power Seating System Recline Only	MP Criteria: Procedure/service reviewed against Medical		
E1003	Without Shear Reduction	Policy Criteria. Submit for Recommended Clinical Review to		
		avoid post-service review.	_	_
	Wheelchair Accessory Power Seating System Recline Only	MP Criteria: Procedure/service reviewed against Medical		
E1004	With Mechanical Shear Reduction	Policy Criteria. Submit for Recommended Clinical Review to		
	The state of the s	avoid post-service review.	_	-
	Wheelchair Accessory Power Seating System Recline Only	MP Criteria: Procedure/service reviewed against Medical		
E1005	With Power Shear Reduction	Policy Criteria. Submit for Recommended Clinical Review to		
	With Fower shear neadersh	avoid post-service review.	_	-
	Wheelchair Accessory Power Seating System Combination	MP Criteria: Procedure/service reviewed against Medical		
E1006	Tilt And Recline Without Shear Reduction	Policy Criteria. Submit for Recommended Clinical Review to		
	The And Recinic Without Shear Neduction	avoid post-service review.	-	-
	Wheelchair Accessory Power Seating System Combination	MP Criteria: Procedure/service reviewed against Medical		
E1007	Tilt And Recline With Mechanical Shear Reduction	Policy Criteria. Submit for Recommended Clinical Review to		
21007	The And Necline With Medidilical Shedi Neduction	avoid post-service review.	-	-
		avoia post-service review.		!

	Wheelchair Accessory Power Seating System Combination	MP Criteria: Procedure/service reviewed against Medical			
E1008	Tilt And Recline With Power Shear Reduction	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Wheelchair Accessory Addition To Power Seating System	MP Criteria: Procedure/service reviewed against Medical			
E1009	Mechanically Linked Leg Elevation System Including	Policy Criteria. Submit for Recommended Clinical Review to			
11009	, , , , , ,	l i	_	-	-
	Pushrod And Leg Rest Each	avoid post-service review.			
	Wheelchair Accessory Addition To Power Seating System	MP Criteria: Procedure/service reviewed against Medical			
E1010	Power Leg Elevation System Including Leg Rest Pair	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Wheelchair Accessory Addition To Power Seating System	MP Criteria: Procedure/service reviewed against Medical			
E1012	,	Policy Criteria. Submit for Recommended Clinical Review to			
21012		avoid post-service review.	_	-	_
	System Any Type Each	·			
	Manual Adult Size Wheelchair Includes Tilt In Space	MP Criteria: Procedure/service reviewed against Medical			
E1161		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
E4220	Wheelchair Pediatric Size Not Otherwise Specified	Unlisted: Procedure/service not specifically defined or			
E1229		classified, maybe subject to contract/clinical review.	_	-	_
	Power Operated Vehicle (Three Or Four Wheel Nonhighway)				
E1230		Policy Criteria. Submit for Recommended Clinical Review to			
E1230	Specify Brand Name And Model Number	·	-	-	-
		avoid post-service review.			
	Power Wheelchair Pediatric Size Not Otherwise Specified	MP Criteria: Procedure/service reviewed against Medical			
		Policy Criteria. Submit for Recommended Clinical Review to			
54000		avoid post-service review.			
E1239		Unlisted or Undefined: Procedures/services not specifically	_	_	_
		defined or classified, maybe subject to contract/clinical			
		i i			
	Wile introduction Molle to Doubele	review.			Effective
E1301	Whirlpool Tub Walk-In Portable	Non Covered: Procedure/service not covered by the Plan.	. / /		
		Not subject to pre-service review.	4/24/2024	_	4/24/2024
E1399	Durable Medical Equipment Miscellaneous	Unlisted: Procedure/service not specifically defined or			
L1399		classified, maybe subject to contract/clinical review.	_	-	_
	Tablo Hemodialysis System For The Billable Dialysis Service	MP Criteria: Procedure/service reviewed against Medical			
E1629	·	Policy Criteria. Submit for Recommended Clinical Review to			
22025		avoid post-service review.	_	_	_
	Waarahla Artificial Kidnay Fach	EIU: Procedure/service not reimbursed by the Plan. Not			
E4.600	Wearable Artificial Kidney Each				
E1632		subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
E1699	Dialysis Equipment Not Otherwise Specified	Unlisted: Procedure/service not specifically defined or			
E1033		classified, maybe subject to contract/clinical review.	_	-	-
	Jaw Motion Rehabilitation System	EIU: Procedure/service not reimbursed by the Plan. Not			
E1700	saw Wodon Kenasinadion System	subject to pre-service review. Check EIU policy, which is			
L1700		* * * * * * * * * * * * * * * * * * * *	_	-	-
		one of our Clinical Payment and Coding Policy (CPCP).			
	Replacement Cushions For Jaw Motion Rehabilitation	EIU: Procedure/service not reimbursed by the Plan. Not			
E1701	System Pkg. Of 6	subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Replacement Measuring Scales For Jaw Motion	EIU: Procedure/service not reimbursed by the Plan. Not			
E1702	Rehabilitation System Pkg. Of 200	subject to pre-service review. Check EIU policy, which is			
	Terrasination system 1 kg. of 200	one of our Clinical Payment and Coding Policy (CPCP).	-	_	_
		one of our chilical rayment and coding Policy (CPCP).			

	Pulse Generator System For Tympanic Treatment Of	MP Criteria: Procedure/service reviewed against			
E2120	Inner Ear Endolymphatic Fluid	Medical Policy Criteria. Submit for Recommended			
	· ·	Clinical Review to avoid post-service review.	5/1/2024		Add effective 05/01/2024
	Complex Rehabilitative Power Wheelchair Accessory	MP Criteria: Procedure/service reviewed against			
E2298	Power Seat Elevation System Any Type	Medical Policy Criteria. Submit for Recommended		_	
		Clinical Review to avoid post-service review.	4/1/2024		Add effective 04/01/2024
	Wheelchair accessory, power seat elevation system, any	MP Criteria: Procedure/service reviewed against Medical			
E2300	type	Policy Criteria. Submit for Recommended Clinical Review to		_	_
		avoid post-service review.	9/1/2020		
52204	Wheelchair Accessory Power Standing System Any Type	MP Criteria: Procedure/service reviewed against Medical			
E2301		Policy Criteria. Submit for Recommended Clinical Review to	_	-	-
	Power Wheelchair Accessory Electronic Connection	avoid post-service review.			
	Between Wheelchair Controller And One Power Seating	MP Criteria: Procedure/service reviewed against Medical			
E2310	System Motor Including All Related Electronics Indicator	Policy Criteria. Submit for Recommended Clinical Review to			
	Feature Mechanical Function Selection Switch And Fixed	avoid post-service review.	_	_	[
	Mounting Hardware	· ·			
	Power Wheelchair Accessory Electronic Connection				
	Between Wheelchair Controller And Two Or More Power	MP Criteria: Procedure/service reviewed against Medical			
E2311	Seating System Motors Including All Related Electronics	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Indicator Feature Mechanical Function Selection Switch	avoid post-service review.			
	And Fixed Mounting Hardware	NAD Critoria: Dragoduro/somica reviewed against Medical			
E2312	Power Wheelchair Accessory Hand Or Chin Control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to			
L2312	Interface Mini-Proportional	avoid post-service review.	-	-	-
	Power Wheelchair Accessory Harness For Upgrade To	MP Criteria: Procedure/service reviewed against Medical			
E2313	Expandable Controller	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Power Wheelchair Accessory Hand Control Interface	MP Criteria: Procedure/service reviewed against Medical			
E2321	Remote Joystick Nonproportional Including All Related	Policy Criteria. Submit for Recommended Clinical Review to			
	Electronics Mechanical Stop Switch And Fixed Mounting	avoid post-service review.		_	_
	Hardware Power Wheelchair Accessory Hand Control Interface				
	Multiple Mechanical Switches Nonproportional Including	MP Criteria: Procedure/service reviewed against Medical			
E2322	All Related Electronics Mechanical Stop Switch And Fixed	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Mounting Hardware	avoid post-service review.			
	Power Wheelchair Accessory Specialty Joystick Handle For	MP Criteria: Procedure/service reviewed against Medical			
E2323	Hand Control Interface Prefabricated	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Power Wheelchair Accessory Chin Cup For Chin Control	MP Criteria: Procedure/service reviewed against Medical			
E2324	Interface	Policy Criteria. Submit for Recommended Clinical Review to	_	_	-
	Devices Wheelshein Assessed Circles of D. Wilder	avoid post-service review.			
	Power Wheelchair Accessory Sip And Puff Interface	MP Criteria: Procedure/service reviewed against Medical			
E2325	Nonproportional Including All Related Electronics Mechanical Stop Switch, And Manual Swingaway Mounting	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
E2325	Mechanical Stop Switch And Manual Swingaway Mounting Hardware	•		-	-

	Power Wheelchair Accessory Breath Tube Kit For Sip And	MP Criteria: Procedure/service reviewed against Medical			1
E2326	Puff Interface	Policy Criteria. Submit for Recommended Clinical Review to			
L2320	Full illerrace	avoid post-service review.	-	-	_
	Power Wheelchair Accessory Head Control Interface	avoid post-service review.			
	·	MP Criteria: Procedure/service reviewed against Medical			
E2327	Mechanical Proportional Including All Related Electronics	Policy Criteria. Submit for Recommended Clinical Review to	_	L	
	Mechanical Direction Change Switch And Fixed Mounting	avoid post-service review.			
	Hardware				
	Power Wheelchair Accessory Head Control Or Extremity	MP Criteria: Procedure/service reviewed against Medical			
E2328	Control Interface Electronic Proportional Including All	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Related Electronics And Fixed Mounting Hardware	avoid post-service review.			
	Power Wheelchair Accessory Head Control Interface				
	Contact Switch Mechanism Nonproportional Including All	MP Criteria: Procedure/service reviewed against Medical			
E2329	Related Electronics Mechanical Stop Switch Mechanical	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Direction Change Switch Head Array And Fixed Mounting	avoid post-service review.			
	Hardware				
	Power Wheelchair Accessory Head Control Interface				
	Proximity Switch Mechanism Nonproportional Including All	MP Criteria: Procedure/service reviewed against Medical			
E2330	Related Electronics Mechanical Stop Switch Mechanical	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Direction Change Switch Head Array And Fixed Mounting	avoid post-service review.			
	Hardware				
	Power Wheelchair Accessory Attendant Control	MP Criteria: Procedure/service reviewed against Medical			
E2331	Proportional Including All Related Electronics And Fixed	Policy Criteria. Submit for Recommended Clinical Review to			
	Mounting Hardware	avoid post-service review.	_		_
	Power Wheelchair Accessory Nonstandard Seat Frame	MP Criteria: Procedure/service reviewed against Medical			
E2340	Width 20-23 Inches	Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review.	_	_	_
	Power Wheelchair Accessory Nonstandard Seat Frame	MP Criteria: Procedure/service reviewed against Medical			
E2341	Width 24-27 Inches	Policy Criteria. Submit for Recommended Clinical Review to			
	Width 21 27 mones	avoid post-service review.	_	_	-
	Power Wheelchair Accessory Nonstandard Seat Frame	MP Criteria: Procedure/service reviewed against Medical			
E2342	Depth 20 Or 21 Inches	Policy Criteria. Submit for Recommended Clinical Review to			
	beptil 20 of 21 menes	avoid post-service review.	_	_	-
	Power Wheelchair Accessory Nonstandard Seat Frame	MP Criteria: Procedure/service reviewed against Medical			
E2343	Depth 22-25 Inches	Policy Criteria. Submit for Recommended Clinical Review to			
L2343	Deptil 22-23 litches	avoid post-service review.	-	-	_
	Power Wheelchair Accessory Electronic Interface To	MP Criteria: Procedure/service reviewed against Medical			
E2351	· · · · · · · · · · · · · · · · · · ·	Policy Criteria. Submit for Recommended Clinical Review to			
L2331	Control Interface	avoid post-service review.	-	-	_
	Power Wheelchair Accessory Hand Or Chin Control	MP Criteria: Procedure/service reviewed against Medical			
E2373	· · · · · · · · · · · · · · · · · · ·	Policy Criteria. Submit for Recommended Clinical Review to			
E23/3	Interface Compact Remote Joystick Proportional Including	·	_	-	-
	Fixed Mounting Hardware	avoid post-service review.			
	Power Wheelchair Accessory Hand Or Chin Control	MP Criteria: Procedure/service reviewed against Medical			
E2374	Interface Standard Remote Joystick (Not Including	Policy Criteria. Submit for Recommended Clinical Review to	_	L	_
	Controller) Proportional Including All Related Electronics	avoid post-service review.	=	_	_
	And Fixed Mounting Hardware Replacement Only				

	Power Wheelchair Accessory Non-Expandable Controller	MP Criteria: Procedure/service reviewed against Medical			T
E2375	Including All Related Electronics And Mounting Hardware	Policy Criteria. Submit for Recommended Clinical Review to			
L2373	Replacement Only	avoid post-service review.	-	-	-
	Power Wheelchair Accessory Expandable Controller	MP Criteria: Procedure/service reviewed against Medical			
E2376	· ·	Policy Criteria. Submit for Recommended Clinical Review to			
L2370	Including All Related Electronics And Mounting Hardware	'	-	-	_
	Replacement Only	avoid post-service review. MP Criteria: Procedure/service reviewed against Medical			
F2277	Power Wheelchair Accessory Expandable Controller	Policy Criteria. Submit for Recommended Clinical Review to			
E2377	Including All Related Electronics And Mounting Hardware	'	-	-	-
	Upgrade Provided At Initial Issue	avoid post-service review.			
F2F00	Speech Generating Device Digitized Speech Using Pre-	MP Criteria: Procedure/service reviewed against Medical			
E2500	Recorded Messages Less Than Or Equal To 8 Minutes	Policy Criteria. Submit for Recommended Clinical Review to	-	-	_
	Recording Time	avoid post-service review.			
	Speech Generating Device Digitized Speech Using Pre-	MP Criteria: Procedure/service reviewed against Medical			
E2502	Recorded Messages Greater Than 8 Minutes But Less Than	Policy Criteria. Submit for Recommended Clinical Review to	-	_	_
	Or Equal To 20 Minutes Recording Time	avoid post-service review.			
	Speech Generating Device Digitized Speech Using Pre-	MP Criteria: Procedure/service reviewed against Medical			
E2504	Recorded Messages Greater Than 20 Minutes But Less Than	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Or Equal To 40 Minutes Recording Time	avoid post-service review.			
	Speech Generating Device Digitized Speech Using Pre-	MP Criteria: Procedure/service reviewed against Medical			
E2506	Recorded Messages Greater Than 40 Minutes Recording	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Time	avoid post-service review.			
	Speech Generating Device Synthesized Speech Requiring	MP Criteria: Procedure/service reviewed against Medical			
E2508	Message Formulation By Spelling And Access By Physical	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Contact With The Device	avoid post-service review.			
	Speech Generating Device Synthesized Speech Permitting	MP Criteria: Procedure/service reviewed against Medical			
E2510	Multiple Methods Of Message Formulation And Multiple	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Methods Of Device Access	avoid post-service review.			
	Speech Generating Software Program For Personal	MP Criteria: Procedure/service reviewed against Medical			
E2511	Computer Or Personal Digital Assistant	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Accessory For Speech Generating Device Mounting System	MP Criteria: Procedure/service reviewed against Medical			
E2512		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Accessory For Speech Generating Device Not Otherwise	MP Criteria: Procedure/service reviewed against Medical			
	Classified	Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review.			
E2599		Unlisted or Undefined: Procedures/services not specifically	_	-	_
		defined or classified, maybe subject to contract/clinical			
		review.			
	Wheelchair Seat Cushion Powered	MP Criteria: Procedure/service reviewed against Medical			
E2610		Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review.	-	_	-
	Speech Volume Modulation System Any Type Including All	EIU: Procedure/service not reimbursed by the Plan. Not			
E3000	Components And Accessories	subject to pre-service review. Check EIU policy, which is			
	Components And Accessories		5/15/2024	_	Add effective 05/15/2024
		one or our chimear rayment and country to they (or or).	J 13/ LULT		7.100 CHECUVE 03/13/2024

E3000	Speech Volume Modulation System Any Type Including All Components And Accessories	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
G0176	Activity Therapy Such As Music Dance Art Or Play Therapies Not For Recreation Related To The Care And Treatment Of Patient'S Disabling Mental Health Problems Per Session (45 Minutes Or More)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	-	-
G0219	Pet Imaging Whole Body; Melanoma For Non-Covered Indications	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS.	-	_	_
G0235	Pet Imaging Any Site Not Otherwise Specified	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	-	_	-
G0252	Pet Imaging Full And Partial-Ring Pet Scanners Only For Initial Diagnosis Of Breast Cancer And/Or Surgical Planning For Breast Cancer (E. G. Initial Staging Of Axillary Lymph Nodes)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS.	-	_	-
G0255	Current Perception Threshold/Sensory Nerve Conduction Test (Snct) Per Limb Any Nerve	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	_	_
G0276	Blinded Procedure For Lumbar Stenosis Percutaneous Image-Guided Lumbar Decompression (Pild) Or Placebo-Control Performed In An Approved Coverage With Evidence Development (Ced) Clinical Trial	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	_	_
G0277	Hyperbaric Oxygen Under Pressure Full Body Chamber Per 30 Minute Interval	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	-	-	-
G0281	Electrical Stimulation (Unattended) To One Or More Areas For Chronic Stage Iii And Stage Iv Pressure Ulcers Arterial Ulcers Diabetic Ulcers And Venous Statsis Ulcers Not Demonstrating Measurable Signs Of Healing After 30 Days Of Conventional Care As Part Of A Therapy Plan Of Care	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	_
G0282	Electrical Stimulation (Unattended) To One Or More Areas For Wound Care Other Than Described In G0281	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	-	-
G0289	Arthroscopy Knee Surgical For Removal Of Loose Body Foreign Body Debridement/Shaving Of Articular Cartilage (Chrondroplasty) At The Time Of Other Surgical Knee Arthroscopy In A Different Compartment Of The Same Knee	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon.	1/1/2024	-	Moved from PA to Recommended Clinical Review 01/01/2024
G0293	Noncovered Surgical Procedure(S) Using Conscious Sedation Regional General Or Spinal Anesthesia In A Medicare Qualifying Clinical Trial Per Day	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-

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	Noncovered Procedure(S) Using Either No Anesthesia Or	Non Covered: Procedure/service not covered by the Plan.			
G0294	Local Anesthesia Only In A Medicare Qualifying Clinical Trial	Not subject to pre-service review.	_	_	_
	Per Day	· ·			
	Electromagnetic Therapy To One Or More Areas For	EIU: Procedure/service not reimbursed by the Plan. Not			
G0295	Wound Care Other Than Described In G0329 Or For Other	subject to pre-service review. Check EIU policy, which is	_	_	_
	Uses	one of our Clinical Payment and Coding Policy (CPCP).			
	Electromagnetic Therapy To One Or More Areas For Chronic				
	Stage Iii And Stage Iv Pressure Ulcers Arterial Ulcers	EIU: Procedure/service not reimbursed by the Plan. Not			
G0329	Diabetic Ulcers And Venous Stasis Ulcers Not Demonstrating	subject to pre-service review. Check EIU policy, which is			
00329	Measurable Signs Of Healing After 30 Days Of Conventional		_	_	-
	Care As Part Of A Therapy Plan Of Care	one of our Clinical Payment and Coding Policy (CPCP).			
	''				
	Image-Guided Robotic Linear Accelerator-Based Stereotactic	MP Criteria: Procedures/services reviewed against Medical			
G0339	Radiosurgery Complete Course Of Therapy In One Session	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Or First Session Of Fractionated Treatment	avoid post-service review by Carelon.			
	Image-Guided Robotic Linear Accelerator-Based Stereotactic				
	Radiosurgery Delivery Including Collimator Changes And	MP Criteria: Procedures/services reviewed against Medical			
G0340	Custom Plugging Fractionated Treatment All Lesions Per	Policy Criteria. Submit for Recommended Clinical Review to	_		
	Session Second Through Fifth Sessions Maximum Five	avoid post-service review by Carelon.	_	_	_
	Sessions Per Course Of Treatment	, '			
	Percutaneous Islet Cell Transplant Includes Portal Vein	MP Criteria: Procedure/service reviewed against Medical			
G0341	Catheterization And Infusion	Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review.	_	_	_
	Laparoscopy For Islet Cell Transplant Includes Portal Vein	MP Criteria: Procedure/service reviewed against Medical			
G0342	Catheterization And Infusion	Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review.	_	_	_
	Laparotomy For Islet Cell Transplant Includes Portal Vein	MP Criteria: Procedure/service reviewed against Medical			
G0343	Catheterization And Infusion	Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review.	_	_	-
	Intensive Cardiac Rehabilitation; With Or Without	MP Criteria: Procedure/service reviewed against Medical			
G0422	Continuous Ecg Monitoring With Exercise Per Session	Policy Criteria. Submit for Recommended Clinical Review to			
00.122	continuous Edg Wientering With Exercise 1 er session	avoid post-service review.	_	_	-
	Intensive Cardiac Rehabilitation; With Or Without	MP Criteria: Procedure/service reviewed against Medical			
G0423	Continuous Ecg Monitoring; Without Exercise Per Session	Policy Criteria. Submit for Recommended Clinical Review to			
00 123	continuous Eeg Monitoring, Without Exercise 1 er session	avoid post-service review.	_	_	_
	Collagen Meniscus Implant Procedure For Filling Meniscal	EIU: Procedure/service not reimbursed by the Plan. Not			
G0428	Defects (E.G. Cmi Collagen Scaffold Menaflex)	subject to pre-service review. Check EIU policy, which is			
55 120	Servers (E.O. Citil Collage II Scattola Wicharles)	one of our Clinical Payment and Coding Policy (CPCP).	-	_	_
	Dermal Filler Injection(S) For The Treatment Of Facial	MP Criteria: Procedure/service reviewed against Medical			
G0429	Lipodystrophy Syndrome (Lds) (E.G. As A Result Of Highly	Policy Criteria. Submit for Recommended Clinical Review to			
30723	Active Antiretroviral Therapy.)	avoid post-service review.	-	-	-
	Low Dose Rate (Ldr) Prostate Brachytherapy Services	MP Criteria: Procedures/services reviewed against Medical			
G0458		Policy Criteria. Submit for Recommended Clinical Review to			
00+30	Composite Rate	·	-	-	-
		avoid post-service review by Carelon.		ļ	ļ

	Autologous Platalet Bish Plasma Or Other Pland Poriusa				
	Autologous Platelet Rich Plasma Or Other Blood-Derived	FILL Beautiful of the State and the State Make			
	Product For Non-Diabetic Chronic Wounds/Ulcers Including				
G0460	As Applicable Phlebotomy Centrifugation Or Mixing And All		_	_	-
	Other Preparatory Procedures Administration And	one of our Clinical Payment and Coding Policy (CPCP).			
	Dressings Per Treatment				
	Autologous Platelet Rich Plasma (Prp) Or Other Blood-				
	Derived Product For Diabetic Chronic Wounds/Ulcers Using	EIU: Procedure/service not reimbursed by the Plan. Not			
G0465	An Fda-Cleared Device For This Indication (Includes As	subject to pre-service review. Check EIU policy, which is			
00405	Applicable Administration Dressings Phlebotomy	· · · · ·	_	-	-
	Centrifugation Or Mixing And All Other Preparatory	one of our Clinical Payment and Coding Policy (CPCP).			
	Procedures Per Treatment)				
	Alcohol And/Or Substance (Other Than Tobacco) Misuse	Non-Covered Broodyna/on-in- not severed by the Bloo			
G2011	Structured Assessment (E.G. Audit Dast) And Brief	Non Covered: Procedure/service not covered by the Plan.			_
	Intervention 5-14 Minutes	Not subject to pre-service review.			
	Office Or Other Outpatient Visit For The Evaluation And				
	Management Of An Established Patient That Requires The				
	Supervision Of A Physician Or Other Qualified Health Care	MP Criteria: Procedure/service reviewed against Medical			
G2082	Professional And Provision Of Up To 56 Mg Of Esketamine	Policy Criteria. Submit for Recommended Clinical Review to	_	-	_
	Nasal Self-Administration Includes 2 Hours Post-	avoid post-service review.			
	Administration Observation				
	Office Or Other Outpatient Visit For The Evaluation And				
	Management Of An Established Patient That Requires The				
	Supervision Of A Physician Or Other Qualified Health Care	MP Criteria: Procedure/service reviewed against Medical			
G2083	Professional And Provision Of Greater Than 56 Mg	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Esketamine Nasal Self-Administration Includes 2 Hours Post-	avoid post-service review.			
	Administration Observation				
	Ultrasonic Guidance For Placement Of Radiation Therapy	MP Criteria: Procedures/services reviewed against Medical			
G6001	Fields	Policy Criteria. Submit for Recommended Clinical Review to			
00001	Ticlus	avoid post-service review by Carelon.	_	_	-
	Stereoscopic X-Ray Guidance For Localization Of Target	MP Criteria: Procedures/services reviewed against Medical			
G6002	Volume For The Delivery Of Radiation Therapy	Policy Criteria. Submit for Recommended Clinical Review to			
00002	volume for the belivery of Radiation Therapy	avoid post-service review by Carelon.	_	_	-
	Radiation Treatment Delivery Single Treatment Area Single	MP Criteria: Procedures/services reviewed against Medical			
G6003	Port Or Parallel Opposed Ports Simple Blocks Or No Blocks:	Policy Criteria. Submit for Recommended Clinical Review to			
00003	Up To 5Mev	avoid post-service review by Carelon.	_	-	-
	Radiation Treatment Delivery Single Treatment Area Single	MP Criteria: Procedures/services reviewed against Medical			
G6004	Port Or Parallel Opposed Ports Simple Blocks Or No Blocks:	Policy Criteria. Submit for Recommended Clinical Review to			
00004	6-10Mev	avoid post-service review by Carelon.	_	-	-
	Radiation Treatment Delivery Single Treatment Area Single	MP Criteria: Procedures/services reviewed against Medical			
G6005		Policy Criteria. Submit for Recommended Clinical Review to			
G0005	Port Or Parallel Opposed Ports Simple Blocks Or No Blocks:	·	_	-	-
	11-19Mev	avoid post-service review by Carelon. MP Criteria: Procedures/services reviewed against Medical			
ccooc	Radiation Treatment Delivery Single Treatment Area Single				
G6006	Port Or Parallel Opposed Ports Simple Blocks Or No Blocks:	Policy Criteria. Submit for Recommended Clinical Review to	_	-	-
	20Mev Or Greater	avoid post-service review by Carelon.			
	Radiation Treatment Delivery 2 Separate Treatment Areas	MP Criteria: Procedures/services reviewed against Medical			
G6007	3 Or More Ports On A Single Treatment Area Use Of	Policy Criteria. Submit for Recommended Clinical Review to	_	-	-
	Multiple Blocks: Up To 5Mev	avoid post-service review by Carelon.			

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	Radiation Treatment Delivery 2 Separate Treatment Areas	MP Criteria: Procedures/services reviewed against Medical			
G6008	3 Or More Ports On A Single Treatment Area Use Of	Policy Criteria. Submit for Recommended Clinical Review to	_	-	_
	Multiple Blocks: 6-10Mev	avoid post-service review by Carelon.			
	Radiation Treatment Delivery 2 Separate Treatment Areas	MP Criteria: Procedures/services reviewed against Medical			
G6009	3 Or More Ports On A Single Treatment Area Use Of	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Multiple Blocks: 11-19Mev	avoid post-service review by Carelon.			
	Radiation Treatment Delivery 2 Separate Treatment Areas	MP Criteria: Procedures/services reviewed against Medical			
G6010	3 Or More Ports On A Single Treatment Area Use Of	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Multiple Blocks: 20 Mev Or Greater	avoid post-service review by Carelon.			
	Radiation Treatment Delivery 3 Or More Separate	MP Criteria: Procedures/services reviewed against Medical			
G6011	Treatment Areas Custom Blocking Tangential Ports	Policy Criteria. Submit for Recommended Clinical Review to			
90011	Wedges Rotational Beam Compensators Electron Beam;	· ·	_	-	-
	Up To 5Mev	avoid post-service review by Carelon.			
	Radiation Treatment Delivery 3 Or More Separate	MD Critoria: Procedures (convices reviewed against Medical			
CC012	Treatment Areas Custom Blocking Tangential Ports	MP Criteria: Procedures/services reviewed against Medical			
G6012	Wedges Rotational Beam Compensators Electron Beam; 6-	Policy Criteria. Submit for Recommended Clinical Review to	_	-	-
	10Mev	avoid post-service review by Carelon.			
	Radiation Treatment Delivery 3 Or More Separate	AAD Colored and any for a factor of a sector AA affect			
00010	Treatment Areas Custom Blocking Tangential Ports	MP Criteria: Procedures/services reviewed against Medical			
G6013	Wedges Rotational Beam Compensators Electron Beam;	Policy Criteria. Submit for Recommended Clinical Review to	_	-	_
	11-19Mev	avoid post-service review by Carelon.			
	Radiation Treatment Delivery 3 Or More Separate				
	Treatment Areas Custom Blocking Tangential Ports	MP Criteria: Procedures/services reviewed against Medical			
G6014	Wedges Rotational Beam Compensators Electron Beam;	Policy Criteria. Submit for Recommended Clinical Review to	_	-	_
	20Mev Or Greater	avoid post-service review by Carelon.			
	Intensity Modulated Treatment Delivery Single Or Multiple				
	Fields/Arcs Via Narrow Spatially And Temporally Modulated	MP Criteria: Procedures/services reviewed against Medical			
G6015	Beams Binary Dynamic Mlc Per Treatment Session	Policy Criteria. Submit for Recommended Clinical Review to	_	-	_
		avoid post-service review by Carelon.			
	Compensator-Based Beam Modulation Treatment Delivery				
	Of Inverse Planned Treatment Using 3 Or More High	MP Criteria: Procedures/services reviewed against Medical			
G6016	Resolution (Milled Or Cast) Compensator Convergent Beam	Policy Criteria. Submit for Recommended Clinical Review to			
	Modulated Fields Per Treatment Session	avoid post-service review by Carelon.	-	_	_
	Wilder Fields Fer Fredericht Session	,			
	Intra-Fraction Localization And Tracking Of Target Or Patient				
	Motion During Delivery Of Radiation Therapy (Eg 3D	MP Criteria: Procedures/services reviewed against Medical			
G6017	Positional Tracking Gating 3D Surface Tracking) Each	Policy Criteria. Submit for Recommended Clinical Review to	_	-	-
	Fraction Of Treatment	avoid post-service review by Carelon.			
	Left Ventricular Ejection Fraction (Lvef) >= 40% Or	Non Covered: Procedure/service not covered by the Plan.			
G8395	Documentation As Normal Or	Not subject to pre-service review.	-	-	-
	Left Ventricular Ejection Fraction (Lvef) Not Performed Or	Non Covered: Procedure/service not covered by the Plan.			
G8396	Documented	Not subject to pre-service review.	-	-	-
	Dilated Macular Or Fundus Exam Performed Including	Non Covered: Procedure/service not covered by the Plan.			
G8397	Documentation Of The	Not subject to pre-service review.	-	-	-
	Patient With Documented Results Of A Central Dual-Energy	Non Covered: Procedure/service not covered by the Plan.			
G8399	X-Ray Absorptiometry (Dxa) Ever Being Performed	Not subject to pre-service review.	_	_	-
	A hay Absorptionietry (DAa) Ever being renormed	mot subject to pie service review.			

	Patient With Central Dual-Energy X-Ray Absorptiometry	Non Covered: Procedure/service not covered by the Plan.			
G8400	(Dxa) Results Not Documented Reason Not Given	Not subject to pre-service review.	_	_	_
	Lower Extremity Neurological Exam Performed And	Non Covered: Procedure/service not covered by the Plan.			
G8404	Documented	Not subject to pre-service review.	_	_	_
	Lower Extremity Neurological Exam Not Performed	Non Covered: Procedure/service not covered by the Plan.			
G8405	Lower Extremity Neurological Exam Not Performed	Not subject to pre-service review.	_	_	_
	Footwear Evaluation Performed And Documented	Non Covered: Procedure/service not covered by the Plan.			
G8410	Footwear Evaluation Performed And Documented	Not subject to pre-service review.	_	_	_
	Footwear Evaluation Was Not Performed	Non Covered: Procedure/service not covered by the Plan.			
G8415	rootwear Evaluation was not renormed	· ·	_	_	_
	Clinician Decumented That Datient Was Not An Eligible	Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan.			
G8416	Clinician Documented That Patient Was Not An Eligible		_	_	_
	Candidate For Footwear Bmi Is Documented Above Normal Parameters And A Follow-	Not subject to pre-service review.			
G8417	Up Plan Is Documented	·	_	_	_
	Bmi Is Documented Below Normal Parameters And A Follow-	Not subject to pre-service review.			
G8418	Up Plan Is Documented	Not subject to pre-service review.	_	_	_
	Bmi Documented Outside Normal Parameters No Follow-Up				
G8419	Plan Documented No Reason Given	Not subject to pre-service review.	_	_	_
	Bmi Is Documented Within Normal Parameters And No	Non Covered: Procedure/service not covered by the Plan.			
G8420		· ·	_	_	_
	Follow-Up Plan Is Required Bmi Not Documented And No Reason Is Given	Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan.			
G8421	Bill Not Documented And No Reason is given		_	_	_
	Eligible Clinician Attests To Documenting In The Medical	Not subject to pre-service review.			
G8427	Record They Obtained Updated Or Reviewed The Patient'S	Non Covered: Procedure/service not covered by the Plan.			
G0427	· ·	Not subject to pre-service review.	-	-	-
	Current Medications Current List Of Medications Not Documented As Obtained				
G8428		Non Covered: Procedure/service not covered by the Plan.			
G0420	Updated Or Reviewed By The Eligible Clinician Reason Not Given	Not subject to pre-service review.	-	-	-
	Documentation Of A Medical Reason(S) For Not				
	Documenting Updating Or Reviewing The Patient'S Current	Non Covered: Procedure/service not covered by the Plan			
G8430	Medications List (E.G. Patient Is In An Urgent Or Emergent	Not subject to pre-service review.	_	_	_
	Medical Situation)	Not subject to pre-service review.			
	Screening For Depression Is Documented As Being Positive	Non Covered: Procedure/service not covered by the Plan.			
G8431	And A Follow-Up Plan Is Documented	Not subject to pre-service review.	_	_	_
	Depression Screening Not Documented Reason Not Given	Non Covered: Procedure/service not covered by the Plan.			
G8432	Depression screening Not Documented Reason Not Given	Not subject to pre-service review.	_	_	_
	Screening For Depression Not Completed Documented	Non Covered: Procedure/service not covered by the Plan.			
G8433	Patient Or Medical Reason	Not subject to pre-service review.	_	_	_
	Beta-Blocker Therapy Prescribed	Non Covered: Procedure/service not covered by the Plan.			
G8450	beta blocker merapy resembed	Not subject to pre-service review.	_	_	_
	Beta-Blocker Therapy For Lvef <=40% Not Prescribed For	rior subject to pie service review.			
	Reasons Documented By The Clinician (E.G. Low Blood				
	· · · · · · · · · · · · · · · · · · ·	Non Covered: Procedure/service not covered by the Plan.			
G8451	With An Intravenous Positive Inotropic Agent Allergy	Not subject to pre-service review.	_	_	_
	Intolerance Other Medical Reasons Patient Declined Other	The subject to pie service review.			
	Patient Reasons)				

C0453	Beta-Blocker Therapy Not Prescribed	Non Covered: Procedure/service not covered by the Plan.			
G8452		Not subject to pre-service review.	_	-	-
G8465	High Or Very High Risk Of Recurrence Of Prostate Cancer	Non Covered: Procedure/service not covered by the Plan.			
G6405		Not subject to pre-service review.	-	-	-
G8473	Angiotensin Converting Enzyme (Ace) Inhibitor Or	Non Covered: Procedure/service not covered by the Plan.			
00473	Angiotensin Receptor Blocker	Not subject to pre-service review.	-	-	-
	Angiotensin Converting Enzyme (Ace) Inhibitor Or				
	Angiotensin Receptor Blocker (Arb) Therapy Not Prescribed				
	For Reasons Documented By The Clinician (E.G. Allergy	Non Covered: Procedure/service not covered by the Plan.			
G8474	Intolerance Pregnancy Renal Failure Due To Ace Inhibitor	Not subject to pre-service review.	_	_	_
	Diseases Of The Aortic Or Mitral Valve Other Medical	rior subject to pre service review.			
	Reasons) Or (E.G. Patient Declined Other Patient Reasons)				
	Angiotensin Converting Enzyme (Ace) Inhibitor Or	Non Covered: Procedure/service not covered by the Plan.			
G8475	Angiotensin Receptor Blocker (Arb) Therapy Not Prescribed	Not subject to pre-service review.	_	_	_
	Reason Not Given	rior subject to pre service review.			
	Most Recent Blood Pressure Has A Systolic Measurement Of	Non Covered: Procedure/service not covered by the Plan.			
G8476	< 140 Mmhg And A Diastolic Measurement Of < 90 Mmhg	Not subject to pre-service review.	_	_	-
	Most Recent Blood Pressure Has A Systolic Measurement Of				
G8477	>=140 Mmhg And/Or A Diastolic Measurement Of >=90	Non Covered: Procedure/service not covered by the Plan.			
	Mmhg	Not subject to pre-service review.	_	_	-
G8478	Blood Pressure Measurement Not Performed Or	Non Covered: Procedure/service not covered by the Plan.			
G8478	Documented Reason Not Given	Not subject to pre-service review.	_	-	-
G8482	Influenza Immunization Administered Or Previously	Non Covered: Procedure/service not covered by the Plan.			
00402	Received	Not subject to pre-service review.	-	-	-
	Influenza Immunization Was Not Administered For Reasons				
	Documented By Clinician (E.G. Patient Allergy Or Other	Non Covered: Procedure/service not covered by the Plan.			
G8483	Medical Reasons Patient Declined Or Other Patient Reasons	Not subject to pre-service review.	_	_	_
	Vaccine Not Available Or Other System Reasons)	,			
	Influenza Immunization Was Not Administered Reason Not	Non Covered: Procedure/service not covered by the Plan.			
G8484	Given	Not subject to pre-service review.	_	-	-
00010	Other Specified Case Management Service Not Elsewhere	Unlisted: Procedure/service not specifically defined or			
G9012	Classified	classified, maybe subject to contract/clinical review.	_	-	-
	Oncology; Primary Focus Of Visit; Work-Up Evaluation Or	Non Covered: Procedure/service not covered by the Plan.			
G9050	Staging At The Time Of Cancer Diagnosis Or Recurrence (For	Not subject to pre-service review.	_	_	_
	Use In A Medicare-Approved Demonstration Project)	Not subject to pre-service review.			
	Oncology; Primary Focus Of Visit; Treatment Decision-				
	Making After Disease Is Staged Or Restaged Discussion Of				
G9051	Treatment Options Supervising/Coordinating Active Cancer	Non Covered: Procedure/service not covered by the Plan.			
	Directed Therapy Or Managing Consequences Of Cancer	Not subject to pre-service review.	_	_	_
	Directed Therapy (For Use In A Medicare-Approved				
	Demonstration Project)				

	Oncology; Primary Focus Of Visit; Surveillance For Disease				
	Recurrence For Patient Who Has Completed Definitive				
G9052	Cancer-Directed Therapy And Currently Lacks Evidence Of	Non Covered: Procedure/service not covered by the Plan.			
63032	Recurrent Disease; Cancer Directed Therapy Might Be	Not subject to pre-service review.	-	-	_
	Considered In The Future (For Use In A Medicare-Approved				
	Demonstration Project)				
	Oncology; Primary Focus Of Visit; Expectant Management Of				
	Patient With Evidence Of Cancer For Whom No Cancer				
G9053	Directed Therapy Is Being Administered Or Arranged At	Non Covered: Procedure/service not covered by the Plan.			
G9055	Present; Cancer Directed Therapy Might Be Considered In	Not subject to pre-service review.	-	-	-
	The Future (For Use In A Medicare-Approved Demonstration				
	Project)				
	Oncology; Primary Focus Of Visit; Supervising Coordinating				
	Or Managing Care Of Patient With Terminal Cancer Or For				
	Whom Other Medical Illness Prevents Further Cancer	Non Covered: Procedure/service not covered by the Plan.			
G9054	Treatment; Includes Symptom Management End-Of-Life	Not subject to pre-service review.	_	_	_
	Care Planning Management Of Palliative Therapies (For Use	Not subject to pre-service review.			
	In A Medicare-Approved Demonstration Project)				
	Oncology; Primary Focus Of Visit; Other Unspecified Service	Non Covered: Procedure/service not covered by the Plan.			
	Not Otherwise Listed (For Use In A Medicare-Approved	Not subject to pre-service review.			
G9055	Demonstration Project)	Unlisted or Undefined: Procedures/services not specifically	_	_	_
		defined or classified, maybe subject to contract/clinical			
		review.			
	Oncology; Practice Guidelines; Management Adheres To	Non Covered: Procedure/service not covered by the Plan.			
G9056	Guidelines (For Use In A Medicare-Approved Demonstration	Not subject to pre-service review.	_	_	_
	Project)	Thou subject to pre service review.			
	Oncology; Practice Guidelines; Management Differs From				
G9057	Guidelines As A Result Of Patient Enrollment In An	Non Covered: Procedure/service not covered by the Plan.			
	Institutional Review Board Approved Clinical Trial (For Use In	Not subject to pre-service review.	_	_	_
	A Medicare-Approved Demonstration Project)				
	Oncology; Practice Guidelines; Management Differs From				
G9058	Guidelines Because The Treating Physician Disagrees With	Non Covered: Procedure/service not covered by the Plan.			
	Guideline Recommendations (For Use In A Medicare-	Not subject to pre-service review.	_	_	_
	Approved Demonstration Project)				
	Oncology; Practice Guidelines; Management Differs From				
	Guidelines Because The Patient After Being Offered				
G9059	Treatment Consistent With Guidelines Has Opted For	Non Covered: Procedure/service not covered by the Plan.			
	Alternative Treatment Or Management Including No	Not subject to pre-service review.	_	_	_
	Treatment (For Use In A Medicare-Approved Demonstration				
	Project)				
	Oncology; Practice Guidelines; Management Differs From				
cooco	Guidelines For Reason(S) Associated With Patient Comorbid	Non Covered: Procedure/service not covered by the Plan.			
G9060	Illness Or Performance Status Not Factored Into Guidelines	Not subject to pre-service review.	-	-	-
	(For Use In A Medicare-Approved Demonstration Project)				

G9061	Oncology; Practice Guidelines; Patient'S Condition Not Addressed By Available Guidelines (For Use In A Medicare- Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-
G9062	Oncology; Practice Guidelines; Management Differs From Guidelines For Other Reason(S) Not Listed (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-
G9063	Oncology; Disease Status; Limited To Non-Small Cell Lung Cancer; Extent Of Disease Initially Established As Stage I (Prior To Neo-Adjuvant Therapy If Any) With No Evidence Of Disease Progression Recurrence Or Metastases (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-
G9064	Oncology; Disease Status; Limited To Non-Small Cell Lung Cancer; Extent Of Disease Initially Established As Stage Ii (Prior To Neo-Adjuvant Therapy If Any) With No Evidence Of Disease Progression Recurrence Or Metastases (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-
G9065	Oncology; Disease Status; Limited To Non-Small Cell Lung Cancer; Extent Of Disease Initially Established As Stage Iii A (Prior To Neo-Adjuvant Therapy If Any) With No Evidence Of Disease Progression Recurrence Or Metastases (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-
G9066	Oncology; Disease Status; Limited To Non-Small Cell Lung Cancer; Stage Iii B- Iv At Diagnosis Metastatic Locally Recurrent Or Progressive (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	_	-
G9067	Oncology; Disease Status; Limited To Non-Small Cell Lung Cancer; Extent Of Disease Unknown Staging In Progress Or Not Listed (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	_	-
G9068	Oncology; Disease Status; Limited To Small Cell And Combined Small Cell/Non-Small Cell; Extent Of Disease Initially Established As Limited With No Evidence Of Disease Progression Recurrence Or Metastases (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-
G9069	Oncology; Disease Status; Small Cell Lung Cancer Limited To Small Cell And Combined Small Cell/Non-Small Cell; Extensive Stage At Diagnosis Metastatic Locally Recurrent Or Progressive (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-
G9070	Oncology; Disease Status; Small Cell Lung Cancer Limited To Small Cell And Combined Small Cell/Non-Small; Extent Of Disease Unknown Staging In Progress Or Not Listed (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-

G9071	Oncology; Disease Status; Invasive Female Breast Cancer (Does Not Include Ductal Carcinoma In Situ); Adenocarcinoma As Predominant Cell Type; Stage I Or Stage lia-lib; Or T3 N1 M0; And Er And/Or Pr Positive; With No Evidence Of Disease Progression Recurrence Or Metastases (For Use In A Medicare-Approved Demonstration Project)	Not subject to pre-service review.	-	-	_
G9072	Oncology; Disease Status; Invasive Female Breast Cancer (Does Not Include Ductal Carcinoma In Situ); Adenocarcinoma As Predominant Cell Type; Stage I Or Stage Iia-Iib; Or T3 N1 M0; And Er And Pr Negative; With No Evidence Of Disease Progression Recurrence Or Metastases (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	_
G9073	Oncology; Disease Status; Invasive Female Breast Cancer (Does Not Include Ductal Carcinoma In Situ); Adenocarcinoma As Predominant Cell Type; Stage Iiia-Iiib; And Not T3 N1 M0; And Er And/Or Pr Positive; With No Evidence Of Disease Progression Recurrence Or Metastases (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-
G9074	Oncology; Disease Status; Invasive Female Breast Cancer (Does Not Include Ductal Carcinoma In Situ); Adenocarcinoma As Predominant Cell Type; Stage Iiia-Iiib; And Not T3 N1 M0; And Er And Pr Negative; With No Evidence Of Disease Progression Recurrence Or Metastases (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	_
G9075	Oncology; Disease Status; Invasive Female Breast Cancer (Does Not Include Ductal Carcinoma In Situ); Adenocarcinoma As Predominant Cell Type; M1 At Diagnosis Metastatic Locally Recurrent Or Progressive (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-
G9077	Oncology; Disease Status; Prostate Cancer Limited To Adenocarcinoma As Predominant Cell Type; T1-T2C And Gleason 2-7 And Psa < Or Equal To 20 At Diagnosis With No Evidence Of Disease Progression Recurrence Or Metastases (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-
G9078	Oncology; Disease Status; Prostate Cancer Limited To Adenocarcinoma As Predominant Cell Type; T2 Or T3A Gleason 8-10 Or Psa > 20 At Diagnosis With No Evidence Of Disease Progression Recurrence Or Metastases (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-

	Oncology; Disease Status; Prostate Cancer Limited To				
	Adenocarcinoma As Predominant Cell Type; T3B-T4 Any N;	Non Covered: Procedure/service not covered by the Plan.			
G9079	Any T N1 At Diagnosis With No Evidence Of Disease	Not subject to pre-service review.	_	_	_
	Progression Recurrence Or Metastases (For Use In A	, , , , , , , , , , , , , , , , , , , ,			
	Medicare-Approved Demonstration Project)				
	Oncology; Disease Status; Prostate Cancer Limited To				
G9080	Adenocarcinoma; After Initial Treatment With Rising Psa Or	Non Covered: Procedure/service not covered by the Plan.			
	Failure Of Psa Decline (For Use In A Medicare-Approved	Not subject to pre-service review.	-	_	-
	Demonstration Project)				
	Oncology; Disease Status; Prostate Cancer Limited To				
G9083	Adenocarcinoma; Extent Of Disease Unknown Staging In	Non Covered: Procedure/service not covered by the Plan.			
	Progress Or Not Listed (For Use In A Medicare-Approved	Not subject to pre-service review.	-	_	-
	Demonstration Project)				
	Oncology; Disease Status; Colon Cancer Limited To Invasive				
	Cancer Adenocarcinoma As Predominant Cell Type; Extent				
G9084	Of Disease Initially Established As T1-3 N0 M0 With No	Non Covered: Procedure/service not covered by the Plan.			
	Evidence Of Disease Progression Recurrence Or Metastases	Not subject to pre-service review.	_	_	_
	(For Use In A Medicare-Approved Demonstration Project)				
	Oncology; Disease Status; Colon Cancer Limited To Invasive				
	Cancer Adenocarcinoma As Predominant Cell Type; Extent				
G9085	Of Disease Initially Established As T4 N0 M0 With No	Non Covered: Procedure/service not covered by the Plan.			_
	Evidence Of Disease Progression Recurrence Or Metastases	Not subject to pre-service review.			
	(For Use In A Medicare-Approved Demonstration Project)				
	Oncology; Disease Status; Colon Cancer Limited To Invasive				
	Cancer Adenocarcinoma As Predominant Cell Type; Extent				
	Of Disease Initially Established As T1-4 N1-2 M0 With No	Non Covered: Procedure/service not covered by the Plan.			
G9086	Evidence Of Disease Progression Recurrence Or Metastases		_	_	_
	(For Use In A Medicare-Approved Demonstration Project)	not subject to pre service remem			
	(101 Ose III A Medicare-Approved Demonstration Project)				
	Oncology; Disease Status; Colon Cancer Limited To Invasive				
	Cancer Adenocarcinoma As Predominant Cell Type; M1 At				
C0007	Diagnosis Metastatic Locally Recurrent Or Progressive With	Non Covered: Procedure/service not covered by the Plan.			
G9087	Current Clinical Radiologic Or Biochemical Evidence Of	Not subject to pre-service review.	_	-	-
	Disease (For Use In A Medicare-Approved Demonstration				
	Project)				
	Oncology; Disease Status; Colon Cancer Limited To Invasive				
	Cancer Adenocarcinoma As Predominant Cell Type; M1 At				
C0000	Diagnosis Metastatic Locally Recurrent Or Progressive	Non Covered: Procedure/service not covered by the Plan.			
U3000	Without Current Clinical Radiologic Or Biochemical	Not subject to pre-service review.	-	-	-
	Evidence Of Disease (For Use In A Medicare-Approved				
	Demonstration Project)				
G9088	Cancer Adenocarcinoma As Predominant Cell Type; M1 At Diagnosis Metastatic Locally Recurrent Or Progressive Without Current Clinical Radiologic Or Biochemical Evidence Of Disease (For Use In A Medicare-Approved		-	-	-

G9089	Oncology; Disease Status; Colon Cancer Limited To Invasive Cancer Adenocarcinoma As Predominant Cell Type; Extent Of Disease Unknown Staging In Progress Or Not Listed (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	_	_
G9090	Oncology; Disease Status; Rectal Cancer Limited To Invasive Cancer Adenocarcinoma As Predominant Cell Type; Extent Of Disease Initially Established As T1-2 NO MO (Prior To Neo Adjuvant Therapy If Any) With No Evidence Of Disease Progression Recurrence Or Metastases (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-
G9091	Oncology; Disease Status; Rectal Cancer Limited To Invasive Cancer Adenocarcinoma As Predominant Cell Type; Extent Of Disease Initially Established As T3 N0 M0 (Prior To Neo-Adjuvant Therapy If Any) With No Evidence Of Disease Progression Recurrence Or Metastases (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	-	_
G9092	Oncology; Disease Status; Rectal Cancer Limited To Invasive Cancer Adenocarcinoma As Predominant Cell Type; Extent Of Disease Initially Established As T1-3 N1-2 M0 (Prior To Neo-Adjuvant Therapy If Any) With No Evidence Of Disease Progression Recurrence Or Metastases (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-
G9093	Oncology; Disease Status; Rectal Cancer Limited To Invasive Cancer Adenocarcinoma As Predominant Cell Type; Extent Of Disease Initially Established As T4 Any N M0 (Prior To Neo-Adjuvant Therapy If Any) With No Evidence Of Disease Progression Recurrence Or Metastases (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	-	-
G9094	Oncology; Disease Status; Rectal Cancer Limited To Invasive Cancer Adenocarcinoma As Predominant Cell Type; M1 At Diagnosis Metastatic Locally Recurrent Or Progressive (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-
G9095	Oncology; Disease Status; Rectal Cancer Limited To Invasive Cancer Adenocarcinoma As Predominant Cell Type; Extent Of Disease Unknown Staging In Progress Or Not Listed (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-

		I .			
G9096	Oncology; Disease Status; Esophageal Cancer Limited To Adenocarcinoma Or Squamous Cell Carcinoma As Predominant Cell Type; Extent Of Disease Initially Established As T1-T3 N0-N1 Or Nx (Prior To Neo-Adjuvant Therapy If Any) With No Evidence Of Disease Progression Recurrence Or Metastases (For Use In A Medicare- Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-
G9097	Oncology; Disease Status; Esophageal Cancer Limited To Adenocarcinoma Or Squamous Cell Carcinoma As Predominant Cell Type; Extent Of Disease Initially Established As T4 Any N M0 (Prior To Neo-Adjuvant Therapy If Any) With No Evidence Of Disease Progression Recurrence Or Metastases (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
G9098	Oncology; Disease Status; Esophageal Cancer Limited To Adenocarcinoma Or Squamous Cell Carcinoma As Predominant Cell Type; M1 At Diagnosis Metastatic Locally Recurrent Or Progressive (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	-	-
G9099	Oncology; Disease Status; Esophageal Cancer Limited To Adenocarcinoma Or Squamous Cell Carcinoma As Predominant Cell Type; Extent Of Disease Unknown Staging In Progress Or Not Listed (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	-
G9100	Oncology; Disease Status; Gastric Cancer Limited To Adenocarcinoma As Predominant Cell Type; Post RO Resection (With Or Without Neoadjuvant Therapy) With No Evidence Of Disease Recurrence Progression Or Metastases (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-
G9101	Oncology; Disease Status; Gastric Cancer Limited To Adenocarcinoma As Predominant Cell Type; Post R1 Or R2 Resection (With Or Without Neoadjuvant Therapy) With No Evidence Of Disease Progression Or Metastases (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-
G9102	Oncology; Disease Status; Gastric Cancer Limited To Adenocarcinoma As Predominant Cell Type; Clinical Or Pathologic MO Unresectable With No Evidence Of Disease Progression Or Metastases (For Use In A Medicare- Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-
G9103	Oncology; Disease Status; Gastric Cancer Limited To Adenocarcinoma As Predominant Cell Type; Clinical Or Pathologic M1 At Diagnosis Metastatic Locally Recurrent Or Progressive (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-

	Oncology; Disease Status; Gastric Cancer Limited To				
G9104	Adenocarcinoma As Predominant Cell Type; Extent Of	Non Covered: Procedure/service not covered by the Plan.			
65101	Disease Unknown Staging In Progress Or Not Listed (For	Not subject to pre-service review.	-	-	-
	Use In A Medicare-Approved Demonstration Project)				
	Oncology; Disease Status; Pancreatic Cancer Limited To				
	Adenocarcinoma As Predominant Cell Type; Post R0	Non Covered: Procedure/service not covered by the Plan.			
G9105	Resection Without Evidence Of Disease Progression	Not subject to pre-service review.	_	_	_
	Recurrence Or Metastases (For Use In A Medicare-	Not subject to pre-service review.			
	Approved Demonstration Project)				
	Oncology; Disease Status; Pancreatic Cancer Limited To				
C0106	Adenocarcinoma; Post R1 Or R2 Resection With No Evidence	Non Covered: Procedure/service not covered by the Plan.			
G9106	Of Disease Progression Or Metastases (For Use In A	Not subject to pre-service review.	-	-	-
	Medicare-Approved Demonstration Project)				
	Oncology; Disease Status; Pancreatic Cancer Limited To				
G9107	Adenocarcinoma; Unresectable At Diagnosis M1 At	Non Covered: Procedure/service not covered by the Plan.			
G9107	Diagnosis Metastatic Locally Recurrent Or Progressive (For	Not subject to pre-service review.	-	-	-
	Use In A Medicare-Approved Demonstration Project)				
	Oncology; Disease Status; Pancreatic Cancer Limited To				
G9108	Adenocarcinoma; Extent Of Disease Unknown Staging In	Non Covered: Procedure/service not covered by the Pla			
G9108	Progress Or Not Listed (For Use In A Medicare-Approved	Not subject to pre-service review.	-	-	-
	Demonstration Project)				
	Oncology; Disease Status; Head And Neck Cancer Limited To				
	Cancers Of Oral Cavity Pharynx And Larynx With Squamous				
	Cell As Predominant Cell Type; Extent Of Disease Initially				
G9109	Established As T1-T2 And N0 M0 (Prior To Neo-Adjuvant		_	_	_
	Therapy If Any) With No Evidence Of Disease Progression	Not subject to pre-service review.			
	Recurrence Or Metastases (For Use In A Medicare-				
	Approved Demonstration Project)				
	Oncology; Disease Status; Head And Neck Cancer Limited To				
	Cancers Of Oral Cavity Pharynx And Larynx With Squamous				
	Cell As Predominant Cell Type; Extent Of Disease Initially	Non Covered: Procedure/service not covered by the Plan.			
G9110	Established As T3-4 And/Or N1-3 M0 (Prior To Neo-	Not subject to pre-service review.	_	_	_
	Adjuvant Therapy If Any) With No Evidence Of Disease	Not subject to pre-service review.			
	Progression Recurrence Or Metastases (For Use In A				
	Medicare-Approved Demonstration Project)				
	Oncology; Disease Status; Head And Neck Cancer Limited To				
	Cancers Of Oral Cavity Pharynx And Larynx With Squamous	Non Covered: Procedure/service not covered by the Plan.			
G9111	Cell As Predominant Cell Type; M1 At Diagnosis Metastatic	Not subject to pre-service review.	_	_	_
	Locally Recurrent Or Progressive (For Use In A Medicare-	Not subject to pre-service review.			
	Approved Demonstration Project)				
	Oncology; Disease Status; Head And Neck Cancer Limited To				
	Cancers Of Oral Cavity Pharynx And Larynx With Squamous	Non Covered: Procedure/service not covered by the Plan.			
G9112	Cell As Predominant Cell Type; Extent Of Disease Unknown	Not subject to pre-service review.	_	_	_
	Staging In Progress Or Not Listed (For Use In A Medicare-	not subject to pre-service review.			
	Approved Demonstration Project)				

G9113	Oncology; Disease Status; Ovarian Cancer Limited To Epithelial Cancer; Pathologic Stage Ia-B (Grade 1) Without Evidence Of Disease Progression Recurrence Or Metastases (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-
G9114	Oncology; Disease Status; Ovarian Cancer Limited To Epithelial Cancer; Pathologic Stage Ia-B (Grade 2-3); Or Stage Ic (All Grades); Or Stage Ii; Without Evidence Of Disease Progression Recurrence Or Metastases (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	_	-
G9115	Oncology; Disease Status; Ovarian Cancer Limited To Epithelial Cancer; Pathologic Stage Iii-Iv; Without Evidence Of Progression Recurrence Or Metastases (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-
G9116	Oncology; Disease Status; Ovarian Cancer Limited To Epithelial Cancer; Evidence Of Disease Progression Or Recurrence And/Or Platinum Resistance (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-
G9117	Oncology; Disease Status; Ovarian Cancer Limited To Epithelial Cancer; Extent Of Disease Unknown Staging In Progress Or Not Listed (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-
G9123	Oncology; Disease Status; Chronic Myelogenous Leukemia Limited To Philadelphia Chromosome Positive And/Or Bcr- Abl Positive; Chronic Phase Not In Hematologic Cytogenetic Or Molecular Remission (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-
G9124	Oncology; Disease Status; Chronic Myelogenous Leukemia Limited To Philadelphia Chromosome Positive And/Or Bcr- Abl Positive; Accelerated Phase Not In Hematologic Cytogenetic Or Molecular Remission (For Use In A Medicare- Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-
G9125	Oncology; Disease Status; Chronic Myelogenous Leukemia Limited To Philadelphia Chromosome Positive And/Or Bcr- Abl Positive; Blast Phase Not In Hematologic Cytogenetic Or Molecular Remission (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-
G9126	Oncology; Disease Status; Chronic Myelogenous Leukemia Limited To Philadelphia Chromosome Positive And/Or Bcr- Abl Positive; In Hematologic Cytogenetic Or Molecular Remission (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-
G9128	Oncology; Disease Status; Limited To Multiple Myeloma Systemic Disease; Smoldering Stage I (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-

	Oncology; Disease Status; Limited To Multiple Myeloma				
G9129	Systemic Disease; Stage Ii Or Higher (For Use In A Medicare-	Non Covered: Procedure/service not covered by the Plan.			
05125	Approved Demonstration Project)	Not subject to pre-service review.	_	-	-
	Oncology; Disease Status; Limited To Multiple Myeloma				
	Systemic Disease; Extent Of Disease Unknown Staging In	Non Covered: Procedure/service not covered by the Plan.			
G9130	Progress Or Not Listed (For Use In A Medicare-Approved	Not subject to pre-service review.	_	_	_
	Demonstration Project)	The samples to pre-service remem			
	Oncology; Disease Status; Invasive Female Breast Cancer				
	(Does Not Include Ductal Carcinoma In Situ);				
G9131	Adenocarcinoma As Predominant Cell Type; Extent Of	Non Covered: Procedure/service not covered by the Plan.			
	Disease Unknown Staging In Progress Or Not Listed (For	Not subject to pre-service review.		_	_
	Use In A Medicare-Approved Demonstration Project)				
	Oncology; Disease Status; Prostate Cancer Limited To				
	Adenocarcinoma; Hormone-Refractory/Androgen-				
G9132	Independent (E.G. Rising Psa On Anti-Androgen Therapy Or	Non Covered: Procedure/service not covered by the Plan.			
	Post-Orchiectomy); Clinical Metastases (For Use In A	Not subject to pre-service review.		_	_
	Medicare-Approved Demonstration Project)				
	Oncology; Disease Status; Prostate Cancer Limited To				
00400	Adenocarcinoma; Hormone-Responsive; Clinical Metastases	es Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-		
G9133	Or M1 At Diagnosis (For Use In A Medicare-Approved			-	-
	Demonstration Project)				
	Oncology; Disease Status; Non-Hodgkin'S Lymphoma Any				
C0124	Cellular Classification; Stage I li At Diagnosis Not Relapsed	Non Covered: Procedure/service not covered by the Plan.			
G9134	Not Refractory (For Use In A Medicare-Approved	Not subject to pre-service review.	-	-	-
	Demonstration Project)				
	Oncology; Disease Status; Non-Hodgkin'S Lymphoma Any				
C012E	Cellular Classification; Stage Iii Iv Not Relapsed Not	Non Covered: Procedure/service not covered by the Plan.	-		
G9135	Refractory (For Use In A Medicare-Approved Demonstration	Not subject to pre-service review.		_	-
	Project)				
	Oncology; Disease Status; Non-Hodgkin'S Lymphoma				
G9136	Transformed From Original Cellular Diagnosis To A Second	Non Covered: Procedure/service not covered by the Plan.			
G3130	Cellular Classification (For Use In A Medicare-Approved	Not subject to pre-service review.	-	-	-
	Demonstration Project)				
	Oncology; Disease Status; Non-Hodgkin'S Lymphoma Any	Non Covered: Procedure/service not covered by the Plan.			
G9137	Cellular Classification; Relapsed/Refractory (For Use In A	Not subject to pre-service review.	_	_	_
	Medicare-Approved Demonstration Project)	not subject to pre-service review.			
	Oncology; Disease Status; Non-Hodgkin'S Lymphoma Any				
	Cellular Classification; Diagnostic Evaluation Stage Not	Non Covered: Procedure/service not covered by the Plan.			
G9138	Determined Evaluation Of Possible Relapse Or Non-	Not subject to pre-service review.	_	_	_
	Response To Therapy Or Not Listed (For Use In A Medicare-	not subject to pre-service review.			
	Approved Demonstration Project)				
	Oncology; Disease Status; Chronic Myelogenous Leukemia				
	Limited To Philadelphia Chromosome Positive And/Or Bcr-	Non Covered: Procedure/service not covered by the Plan.			
G9139	Abl Positive; Extent Of Disease Unknown Staging In Progress	Not subject to pre-service review.	_	-	-
	Not Listed (For Use In A Medicare-Approved Demonstration	and the second second			
	Project)				

G9140	Frontier Extended Stay Clinic Demonstration; For A Patient Stay In A Clinic Approved For The Cms Demonstration Project; The Following Measures Should Be Present: The Stay Must Be Equal To Or Greater Than 4 Hours; Weather Or Other Conditions Must Prevent Transfer Or The Case Falls Into A Category Of Monitoring And Observation Cases That Are Permitted By The Rules Of The Demonstration; There Is A Maximum Frontier Extended Stay Clinic (Fesc) Visit Of 48 Hours Except In The Case When Weather Or Other Conditions Prevent Transfer; Payment Is Made On Each Period Up To 4 Hours After The First 4 Hours	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	-	_
G9143	Warfarin Responsiveness Testing By Genetic Technique Using Any Method Any Number Of Specimen(S)	MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to	_	-	_
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	avoid post-service review by Carelon. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	_
G9978	Remote In-Home Visit For The Evaluation And Management Of A New Patient For Use Only In A Medicare-Approved Bundled Payments For Care Improvement Advanced (Bpci Advanced) Model Episode Of Care Which Requires These 3 Key Components: A Problem Focused History; A Problem Focused Examination; And Straightforward Medical Decision Making Furnished In Real Time Using Interactive Audio And Video Technology. Counseling And Coordination Of Care With Other Physicians Other Qualified Health Care Professionals Or Agencies Are Provided Consistent With The Nature Of The Problem(S) And The Needs Of The Patient Or The Family Or Both. Usually The Presenting Counseling And Coordination Of Care With Other Physicians Other Qualified Health Care Professionals Or Agencies Are Provided Consistent With The Nature Of The Problem(S) And The Needs Of The Patient Or The Family Or Both. Usually The Presenting Problem(S) Are Self Limited Or Minor. Typically 10 Minutes Are Spent With The Patient Or Family Or Both Via Real Time Audio And Video Intercommunications Technology.	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	

G997	Coordination Of Care With Other Physicians Other Qualified Health Care Professionals Or Agencies Are Provided Consistent With The Nature Of The Problem(S) And The Needs Of The Patient Or The Family Or Both. Usually The Presenting Problem(S) Are Of Low To Moderate Severity. Typically 20 Minutes Are Spent With The Patient Or Family Or Both Via Real Time Audio And Video Intercommunications Technology. Remote In-Home Visit For The Evaluation And Management Of A New Patient For Use Only In A Medicare-Approved Bundled Payments For Care Improvement Advanced (Bpci Advanced) Model Episode Of Care Which Requires These 3 Key Components: A Detailed History; A Detailed Examination; Medical Decision Making Of Low Complexity Furnished In Real Time Using Interactive Audio And Video	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
G998	Technology.Counseling And Coordination Of Care With Other Physicians Other Qualified Health Care Professionals Or Agencies Are Provided Consistent With The Nature Of The Problem(S) And The Needs Of The Patient Or The Family Or Both. Usually The Presenting Problem(S) Are Of Moderate Severity. Typically 30 Minutes Are Spent With The Patient Or Family Or Both Via Real Time Audio And Video Intercommunications Technology.	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_

G9981	C	Coordination Of Care With Other Physicians Other Qualified Health Care Professionals Or Agencies Are Provided Consistent With The Nature Of The Problem(S) And The Needs Of The Patient Or The Family Or Both. Usually The Presenting Problem(S) Are Of Moderate To High Severity. Typically 45 Minutes Are Spent With The Patient Or Family Or Both Via Real Time Audio And Video Intercommunications Technology. Remote In-Home Visit For The Evaluation And Management Of A New Patient For Use Only In A Medicare-Approved Bundled Payments For Care Improvement Advanced (Bpci Advanced) Model Episode Of Care Which Requires These 3 Key Components: A Comprehensive History; A Comprehensive Examination; Medical Decision Making Of High Complexity Furnished In Real Time Using Interactive	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
G9982	C F N T C S	Of Constitution of the Physicians and the Constitution of the Cons	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_

G9983	Approved Bundled Payments For Care Improvement Advanced (Bpci Advanced) Model Episode Of Care Which Requires At Least 2 Of The Following 3 Key Components:A Problem Focused History;A Problem Focused Examination;Straightforward Medical Decision Making Furnished In Real Time Using Interactive Audio And Video Technology.Counseling And Coordination Of Care With Other Physicians Other Qualified Health Care Professionals Or Agencies Are Provided Consistent With The Nature Of The Problem(S) And The Needs Of The Patient Or The Family Or Both. Usually The Presenting Problem(S) Are Self Limited Or Minor. Typically 10 Minutes Are Spent With The Patient Or Family Or Both Via Real Time Audio And Video Intercommunications Technology. Remote In-Home Visit For The Evaluation And Management Of An Established Patient For Use Only In A Medicare- Approved Bundled Payments For Care Improvement	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
G9984	Advanced (Bpci Advanced) Model Episode Of Care Which Requires At Least 2 Of The Following 3 Key Components: An Expanded Problem Focused History; An Expanded Problem Focused Examination; Medical Decision Making Of Low Complexity Furnished In Real Time Using Interactive Audio And Video Technology. Counseling And Coordination Of Care With Other Physicians Other Qualified Health Care Professionals Or Agencies Are Provided Consistent With The Nature Of The Problem(S) And The Needs Of The Patient Or The Family Or Both. Usually The Presenting Problem(S) Are Of Low To Moderate Severity. Typically 15 Minutes Are Spent With The Patient Or Family Or Both Via Real Time Audio And Video Intercommunications Technology.	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_

G9985	And Consideration Of Cons With Other Dhysisians Other	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	
G9986	Tashaalagy Counseling And Coordination Of Care With	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	
G9987	Pacanciliation/Management Compliance With Orders/Plan	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	-	_

	Montal Health Comings Not Otherwice Consided	Unlisted: Procedure/service not specifically defined or			
H0046	Mental Health Services Not Otherwise Specified	classified, maybe subject to contract/clinical review.	_	_	_
	Alcohol And/Or Other Drug Abuse Services Not Otherwise	Unlisted: Procedure/service not specifically defined or			
H0047	Specified Specified	classified, maybe subject to contract/clinical review.	_	_	_
	Injection Abatacept 10 Mg (Code May Be Used For	MP Criteria: Procedure/service reviewed against Medical			
	Medicare When Drug Administered Under The Direct	Policy Criteria. Submit for Recommended Clinical Review to			
J0129	Supervision Of A Physician Not For Use When Drug Is Self	avoid post-service review. Prior Authorization may be	_	_	_
	Administered)	required per contract agreement.			
	Injection Aducanumab-Avwa 2 Mg	MP Criteria: Procedure/service reviewed against Medical			
J0172	injection Addeditation Avwa 2 Mg	Policy Criteria. Submit for Recommended Clinical Review to			
30172		avoid post-service review.	-	-	_
	Injection Lecanemab-Irmb 1 Mg	MP Criteria: Procedure/service reviewed against Medical			
J0174	injection recurrents into 1 Mg	Policy Criteria. Submit for Recommended Clinical Review to			
30174		avoid post-service review.	-	-	_
	Injection Aflibercept Hd 1 Mg	MP Criteria: Procedure/service reviewed against			
10477	injection Ambercept na 1 Mg	-			
J0177		Medical Policy Criteria. Submit for Recommended	- / . /	-	
		Clinical Review to avoid post-service review.	5/1/2024		Add effective 05/01/2024
	Injection Aflibercept 1 Mg	MP Criteria: Procedure/service reviewed against Medical			
J0178		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Injection Brolucizumab-Dbll 1 Mg	MP Criteria: Procedure/service reviewed against Medical			
J0179		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Injection Alemtuzumab 1 Mg	MP Criteria: Procedure/service reviewed against Medical			
J0202		Policy Criteria. Submit for Recommended Clinical Review to			
30202		avoid post-service review. Prior Authorization may be	_	_	-
		required per contract agreement.			
	Injection Olipudase Alfa-Rpcp 1 Mg	MP Criteria: Procedure/service reviewed against Medical			
J0218		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Injection Avalglucosidase Alfa-Ngpt 4 Mg	MP Criteria: Procedure/service reviewed against Medical			
J0219		Policy Criteria. Submit for Recommended Clinical Review to			
30213		avoid post-service review. Prior Authorization may be	_	-	-
		required per contract agreement.			
	Injection Alglucosidase Alfa 10 Mg Not Otherwise Specified				
		Policy Criteria. Submit for Recommended Clinical Review to			
J0220		avoid post-service review.			
		Unlisted or Undefined: Procedures/services not specifically	_	-	-
		defined or classified, maybe subject to contract/clinical			
		review.			
	Injection Patisiran 0.1 Mg	MP Criteria: Procedure/service reviewed against Medical			
J0222		Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review. Prior Authorization may be	_	_	-
		required per contract agreement.			

	Injection Givosiran 0.5 Mg	MP Criteria: Procedure/service reviewed against Medical			
	ingerior content of mg	Policy Criteria. Submit for Recommended Clinical Review to			
J0223		avoid post-service review. Prior Authorization may be	_	_	_
		required per contract agreement.			
	Injection Lumasiran 0.5 Mg	MP Criteria: Procedure/service reviewed against Medical			
10004	, and the second	Policy Criteria. Submit for Recommended Clinical Review to			
J0224		avoid post-service review. Prior Authorization may be	-	_	_
		required per contract agreement.			
	Injection Vutrisiran 1 Mg	MP Criteria: Procedure/service reviewed against Medical			
J0225		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Injection Remdesivir 1Mg	MP Criteria: Procedure/service reviewed against			
J0248		Medical Policy Criteria. Submit for Recommended			
		Clinical Review to avoid post-service review.	5/1/2024		Add effective 05/01/2024
	Injection Alpha 1 Proteinase Inhibitor (Human) Not	Unlisted: Procedure/service not specifically defined or			
J0256	Otherwise Specified 10 Mg	classified, maybe subject to contract/clinical review.	_	_	_
	Injection Belatacept 1 Mg	MP Criteria: Procedure/service reviewed against Medical			
J0485	, , , ,	Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review.	4/1/2024		Add effective 04/01/2024
	Injection Belimumab 10 Mg	MP Criteria: Procedure/service reviewed against Medical			
J0490		Policy Criteria. Submit for Recommended Clinical Review to			
10490		avoid post-service review. Prior Authorization may be	_	_	-
		required per contract agreement.			
	Injection Anifrolumab-Fnia 1 Mg	MP Criteria: Procedure/service reviewed against Medical			
J0491		Policy Criteria. Submit for Recommended Clinical Review to			
30 131		avoid post-service review. Prior Authorization may be	_	-	-
		required per contract agreement.			
	Injection Benralizumab 1 Mg	MP Criteria: Procedure/service reviewed against Medical			
J0517		Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review. Prior Authorization may be	_	_	_
	Literation Bookston with 40 Mg	required per contract agreement. MP Criteria: Procedure/service reviewed against Medical			
	Injection Bezlotoxumab 10 Mg	·			
J0565		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review. Prior Authorization may be required per contract agreement.			
	Injection Cerliponase Alfa 1 Mg	MP Criteria: Procedure/service reviewed against Medical			
	injection cemponase Ana 1 Mg	Policy Criteria. Submit for Recommended Clinical Review to			
J0567		avoid post-service review. Prior Authorization may be	_	_	_
		required per contract agreement.			
	Injection Burosumab-Twza 1 Mg	MP Criteria: Procedure/service reviewed against Medical			
J0584	,	Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review. Prior Authorization may be	_	_	_
		required per contract agreement.			
	Injection Abobotulinumtoxina 5 Units	MP Criteria: Procedure/service reviewed against Medical			
10506		Policy Criteria. Submit for Recommended Clinical Review to			
J0586		avoid post-service review. Prior Authorization may be	-	-	-
		required per contract agreement.			

	Injection Rimabotulinumtoxinb 100 Units	MP Criteria: Procedure/service reviewed against Medical			
	.,,	Policy Criteria. Submit for Recommended Clinical Review to			
J0587		avoid post-service review. Prior Authorization may be	_	_	_
		required per contract agreement.			
	Injection Incobotulinumtoxin A 1 Unit	MP Criteria: Procedure/service reviewed against Medical			
	.,,	Policy Criteria. Submit for Recommended Clinical Review to			
J0588		avoid post-service review. Prior Authorization may be	_	_	_
		required per contract agreement.			
	Injection Daxibotulinumtoxina-Lanm 1 Unit	MP Criteria: Procedure/service reviewed against			
J0589	•	Medical Policy Criteria. Submit for Recommended			
		·	5/15/2024	_	Add effective 05/15/2024
	Injection Certolizumab Pegol 1 Mg (Code May Be Used For	MP Criteria: Procedure/service reviewed against Medical	3/ 13/ 202 1		
	Medicare When Drug Administered Under The Direct	Policy Criteria. Submit for Recommended Clinical Review to			
J0717	Supervision Of A Physician Not For Use When Drug Is Self	avoid post-service review. Prior Authorization may be	_	_	_
	Administered)	required per contract agreement.			
	Injection, cabotegravir, 1mg, fda approved prescription, only				
J0739	for use as hiv pre-exposure prophylaxis (not for use as	Policy Criteria. Submit for Recommended Clinical Review to			
10755	treatment for hiv)	avoid post-service review.	-	3/14/2024	retire effective 03/14/2024
	Injection Cabotegravir And Rilpivirine 2Mg/3Mg	MP Criteria: Procedure/service reviewed against Medical		3/14/2024	10th C Chective 03/14/2024
J0741	injection cubotegravii Ana mipivii ine zivig/sivig	Policy Criteria. Submit for Recommended Clinical Review to			
30741		avoid post-service review.	-	-	_
	Injection Collagenase Clostridium Histolyticum 0.01 Mg	MP Criteria: Procedure/service reviewed against Medical			
	injection conagenase clostificant historyacum 0.01 Mg	Policy Criteria. Submit for Recommended Clinical Review to			
J0775		avoid post-service review. Prior Authorization may be	_	_	_
		required per contract agreement.			
	Injection Crizanlizumab-Tmca 5 Mg	MP Criteria: Procedure/service reviewed against Medical			
	injection cheaning thica 5 Mg	Policy Criteria. Submit for Recommended Clinical Review to			
J0791		avoid post-service review. Prior Authorization may be	_	_	_
		required per contract agreement.			
	Injection Darbepoetin Alfa 1 Microgram (Non-Esrd Use)	MP Criteria: Procedure/service reviewed against Medical			
	injection barbepoetin / ina 1 mile og. am (Non 251 a 656)	Policy Criteria. Submit for Recommended Clinical Review to			
J0881		avoid post-service review. Prior Authorization may be	_	_	_
		required per contract agreement.			
	Injection Cipaglucosidase Alfa-Atga 5 Mg	MP Criteria: Procedure/service reviewed against			
J1203	injection cipagiacosidase Ana Atga 5 Mg				
J1203		Medical Policy Criteria. Submit for Recommended	7/45/2024	-	Add affactive 07/15/2024
		Clinical Review to avoid post-service review.	7/15/2024		Add effective 07/15/2024
	Injection Edaravone 1 Mg	MP Criteria: Procedure/service reviewed against Medical			
J1301		Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review. Prior Authorization may be	_	_	_
		required per contract agreement.			
J1302	Injection Sutimlimab-Jome 10 Mg	MP Criteria: Procedures/services reviewed against Medical			
		Policy Criteria. Submit for Recommended Clinical Review to	_	-	_
		avoid post-service review by BCBS.			
14200	Injection Sutimlimab-Jome 10 Mg	MP Criteria: Procedure/service reviewed against Medical			
J1302		Policy Criteria. Submit for Recommended Clinical Review to	_	-	_
		avoid post-service review.			

	Injection Ravulizumab-Cwvz 10 Mg	MP Criteria: Procedure/service reviewed against Medical			
	,	Policy Criteria. Submit for Recommended Clinical Review to			
J1303		avoid post-service review. Prior Authorization may be	-	-	_
		required per contract agreement.			
	Injection Tofersen 1 Mg	MP Criteria: Procedure/service reviewed against Medical			
J1304	-	Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review.	2/15/2024	_	Add effective 02/15/2024
	Injection Evinacumab-Dgnb 5Mg	MP Criteria: Procedure/service reviewed against Medical			
14205		Policy Criteria. Submit for Recommended Clinical Review to			
J1305		avoid post-service review. Prior Authorization may be	-	-	_
		required per contract agreement.			
	Injection Inclisiran 1 Mg	MP Criteria: Procedure/service reviewed against Medical			
J1306		Policy Criteria. Submit for Recommended Clinical Review to			
11300		avoid post-service review. Prior Authorization may be	_	-	_
		required per contract agreement.			
	Injection Epoprostenol 0.5 Mg	MP Criteria: Procedure/service reviewed against Medical			
J1325		Policy Criteria. Submit for Recommended Clinical Review to			
11525		avoid post-service review. Prior Authorization may be	-	_	_
		required per contract agreement.			
	Injection Etranacogene Dezaparvovec-Drlb Per Therapeutic	MP Criteria: Procedure/service reviewed against Medical			
J1411	Dose	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Injection Valoctocogene Roxaparvovec-Rvox Per Ml	MP Criteria: Procedure/service reviewed against Medical			
J1412	Containing Nominal 2 X 10^13 Vector Genomes	Policy Criteria. Submit for Recommended Clinical Review to		_	
		avoid post-service review.	2/15/2024		Add effective 02/15/2024
	Injection Delandistrogene Moxeparvovec-Rokl Per	MP Criteria: Procedure/service reviewed against Medical			
J1413	Therapeutic Dose	Policy Criteria. Submit for Recommended Clinical Review to		_	
			2/15/2024		Add effective 02/15/2024
	Injection Casimersen 10 Mg	MP Criteria: Procedure/service reviewed against Medical			
J1426		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Injection Viltolarsen 10 Mg	MP Criteria: Procedure/service reviewed against Medical			
J1427		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Injection Eteplirsen 10 Mg	MP Criteria: Procedure/service reviewed against Medical			
J1428		Policy Criteria. Submit for Recommended Clinical Review to	_		_
		avoid post-service review. Prior Authorization may be			
	Injection Colodizan 10 Mg	required per contract agreement. MP Criteria: Procedure/service reviewed against Medical			
11.420	Injection Golodirsen 10 Mg	·			
J1429		Policy Criteria. Submit for Recommended Clinical Review to	-	-	-
	Injection Immune Clobulin (Cute cuie) 100 Mg	avoid post-service review. MP Criteria: Procedure/service reviewed against Medical			
	Injection Immune Globulin (Cutaquig) 100 Mg	Policy Criteria. Submit for Recommended Clinical Review to			
J1551		avoid post-service review. Prior Authorization may be	_	_	_
		· ·			
		required per contract agreement.			

	Injection Immune Globulin (Asceniv) 500 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to			
J1554		avoid post-service review. Prior Authorization may be	_	_	_
		·			
	Injection Immune Clabulin Introveneus Iventilized /F. C.	required per contract agreement.			
	Injection Immune Globulin Intravenous Lyophilized (E. G.	Unlisted: Procedure/service not specifically defined or			
J1566	Powder) Not Otherwise Specified 500 Mg	classified, maybe subject to contract/clinical review. Prior			_
		Authorization may be required per contract agreement.			
	Injection Immune Globulin (Panzyga) Intravenous Non-	MP Criteria: Procedure/service reviewed against Medical			
J1576	Lyophilized (E.G. Liquid) 500 Mg	Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review.			
	Injection Immune Globulin Intravenous Non-Lyophilized	Unlisted: Procedure/service not specifically defined or			
J1599	(E.G. Liquid) Not Otherwise Specified 500 Mg	classified, maybe subject to contract/clinical review. Prior			
11399		Authorization may be required per contract agreement.	_	-	_
		, , ,			
	Injection Brexanolone 1 Mg	MP Criteria: Procedure/service reviewed against Medical			
J1632		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
J1726	Injection Hydroxyprogesterone Caproate (Makena) 10 Mg	Non Covered: Procedure/service not covered by the Plan.	_	_	_
31720		Not subject to pre-service review.			
J1729	Injection Hydroxyprogesterone Caproate Not Otherwise	Unlisted: Procedure/service not specifically defined or			
31723	Specified 10 Mg	classified, maybe subject to contract/clinical review.	-	-	-
J1729	Injection Hydroxyprogesterone Caproate Not Otherwise	Non Covered: Procedure/service not covered by the Plan.	_	_	_
72,23	Specified 10 Mg	Not subject to pre-service review.			
	Injection Ibalizumab-Uiyk 10 Mg	MP Criteria: Procedure/service reviewed against Medical			
J1746		Policy Criteria. Submit for Recommended Clinical Review to			
317 10		avoid post-service review. Prior Authorization may be	_	-	-
		required per contract agreement.			
	Injection Spesolimab-Sbzo 1 Mg	MP Criteria: Procedure/service reviewed against Medical			
J1747		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Injection Inebilizumab-Cdon 1 Mg	MP Criteria: Procedure/service reviewed against Medical			
J1823		Policy Criteria. Submit for Recommended Clinical Review to			
31023		avoid post-service review. Prior Authorization may be	-	-	-
		required per contract agreement.			
	Injection Lanreotide 1 Mg	MP Criteria: Procedure/service reviewed against Medical			
J1930		Policy Criteria. Submit for Recommended Clinical Review to		_	
		avoid post-service review.	4/1/2024		Add effective 04/01/2024
	Injection Leuprolide Acetate For Depot Suspension	MP Criteria: Procedure/service reviewed against Medical			
J1951	(Fensolvi) 0.25 Mg	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Injection Leuprolide Acetate For Depot Suspension (Cipla)	MP Criteria: Procedure/service reviewed against Medical			
J1954	7.5 Mg	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			

	Injection Mepolizumab 1 Mg	MP Criteria: Procedure/service reviewed against Medical			
12402		Policy Criteria. Submit for Recommended Clinical Review to			
J2182		avoid post-service review. Prior Authorization may be	-	-	-
		required per contract agreement.			
	Injection Ziconotide 1 Microgram	MP Criteria: Procedure/service reviewed against Medical			
12270		Policy Criteria. Submit for Recommended Clinical Review to			
J2278		avoid post-service review. Prior Authorization may be	_		Retire effective
		required per contract agreement.		5/31/2024	5/31/2024
	Injection Risankizumab-Rzaa Intravenous 1 Mg	MP Criteria: Procedure/service reviewed against Medical			
J2327		Policy Criteria. Submit for Recommended Clinical Review to	_	_	
		avoid post-service review.			
	Injection Ublituximab-Xiiy 1Mg	MP Criteria: Procedure/service reviewed against Medical			
J2329		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Injection Octreotide Depot Form For Intramuscular	MP Criteria: Procedure/service reviewed against Medical			
J2353	Injection 1 Mg	Policy Criteria. Submit for Recommended Clinical Review to		_	
		avoid post-service review.	4/1/2024		Add effective 04/01/2024
	Injection Octreotide Non-Depot Form For Subcutaneous Or	MP Criteria: Procedure/service reviewed against Medical			
J2354	Intravenous Injection 25 Mcg	Policy Criteria. Submit for Recommended Clinical Review to		_	
		avoid post-service review.	4/1/2024		Add effective 04/01/2024
	Injection Tezepelumab-Ekko 1 Mg	MP Criteria: Procedure/service reviewed against Medical			
J2356		Policy Criteria. Submit for Recommended Clinical Review to			
J2350		avoid post-service review. Prior Authorization may be	-	-	-
		required per contract agreement.			
	Injection Papaverine Hcl Up To 60 Mg	MP Criteria: Procedure/service reviewed against Medical			
J2440		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Injection Pasireotide Long Acting 1 Mg	MP Criteria: Procedure/service reviewed against Medical			
J2502		Policy Criteria. Submit for Recommended Clinical Review to			
12302		avoid post-service review. Prior Authorization may be	_		Retire effective
		required per contract agreement.		4/30/2024	4/30/2024
	Injection Pegunigalsidase Alfa-Iwxj 1 Mg	MP Criteria: Procedure/service reviewed against Medical			
J2508		Policy Criteria. Submit for Recommended Clinical Review to		_	
		avoid post-service review.	2/15/2024		Add effective 02/15/2024
	Injection Faricimab-Svoa 0.1 Mg	MP Criteria: Procedure/service reviewed against Medical			
J2777		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
J2778	Injection Ranibizumab 0.1 Mg	MP Criteria: Procedure/service reviewed against Medical			
		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
J2779	Injection Ranibizumab Via Intravitreal Implant (Susvimo)	MP Criteria: Procedure/service reviewed against Medical			
	0.1 Mg	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Injection Avacincaptad Pegol 0.1 Mg	MP Criteria: Procedure/service reviewed against			
J2782		Medical Policy Criteria. Submit for Recommended			
		Clinical Review to avoid post-service review.	7/15/2024	_	Add effective 07/15/2024
	<u> </u>	SSa. Nevicu to avoid post service review.	., 20, 202 1		1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2

	Injection Romiplostim 10 Micrograms	MP Criteria: Procedure/service reviewed against Medical			
J2796		Policy Criteria. Submit for Recommended Clinical Review to		_	
		avoid post-service review.	4/1/2024		Add effective 04/01/2024
	Injection Eptinezumab-Jjmr 1 Mg	MP Criteria: Procedure/service reviewed against Medical			
12022		Policy Criteria. Submit for Recommended Clinical Review to			
J3032		avoid post-service review. Prior Authorization may be	-	-	_
		required per contract agreement.			
	Injection Romosozumab-Aqqg 1 Mg	MP Criteria: Procedure/service reviewed against Medical			
J3111		Policy Criteria. Submit for Recommended Clinical Review to		_	
		avoid post-service review.	4/1/2024		Add effective 04/01/2024
	Injection Testosterone Enanthate 1Mg	MP Criteria: Procedure/service reviewed against Medical			
J3121		Policy Criteria. Submit for Recommended Clinical Review to			
13121		avoid post-service review. Prior Authorization may be	-	-	_
		required per contract agreement.			
	Injection Testosterone Undecanoate 1 Mg	MP Criteria: Procedure/service reviewed against Medical			
J3145		Policy Criteria. Submit for Recommended Clinical Review to			
33143		avoid post-service review. Prior Authorization may be	-	-	-
		required per contract agreement.			
	Injection Teprotumumab-Trbw 10 Mg	MP Criteria: Procedure/service reviewed against Medical			
J3241		Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review. Prior Authorization may be	_	-	_
		required per contract agreement.			
	Injection Tildrakizumab 1 Mg	MP Criteria: Procedure/service reviewed against Medical			
J3245		Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review. Prior Authorization may be	_	T /0 / /000	Retire effective
		required per contract agreement.		5/31/2024	5/31/2024
	Injection Treprostinil 1 Mg	MP Criteria: Procedure/service reviewed against Medical			
13285		Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review. Prior Authorization may be	_	-	_
		required per contract agreement.			
12222	Injection Triamcinolone Acetonide (Xipere) 1 Mg	MP Criteria: Procedure/service reviewed against Medical			
13299		Policy Criteria. Submit for Recommended Clinical Review to	_	-	_
	Interite a Madelle control to the control of Ma	avoid post-service review.			
	Injection Vedolizumab Intravenous 1 Mg	MP Criteria: Procedure/service reviewed against Medical			
13380		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review. Prior Authorization may be			
	Injection Vertenerfin 0.1 Mg	required per contract agreement. MP Criteria: Procedure/service reviewed against Medical			
J3396	Injection Verteporfin 0.1 Mg	Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review.	-	-	-
	Injection Voretigene Neparvovec-Rzyl 1 Billion Vector	MP Criteria: Procedure/service reviewed against Medical			
	,	Policy Criteria. Submit for Recommended Clinical Review to			
J3398	Genomes	· ·	_	_	_
		avoid post-service review. Prior Authorization may be			
		required per contract agreement.			

	Little Occurrence Alternation Visit Boots and	MD Critoria: Procedure/service reviewed against Medical			
	Injection Onasemnogene Abeparvovec-Xioi Per Treatment	MP Criteria: Procedure/service reviewed against Medical			
J3399	Up To 5X10^15 Vector Genomes	Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review. Prior Authorization may be	_	_	_
		required per contract agreement.			
	Beremagene Geperpavec-Svdt For Topical Administration	MP Criteria: Procedure/service reviewed against Medical			
J3401	Containing Nominal 5 X 10^9 Pfu/Ml Vector Genomes Per	Policy Criteria. Submit for Recommended Clinical Review to		_	
	0.1 MI	avoid post-service review.	2/15/2024		Add effective 02/15/2024
	Unclassified Drugs	Unlisted Dragadura (comice not excellingly defined or			
12.400		Unlisted: Procedure/service not specifically defined or			
J3490		classified, maybe subject to contract/clinical review. Prior	_	_	-
		Authorization may be required per contract agreement.			
	Edetate Disodium Per 150 Mg	MP Criteria: Procedure/service reviewed against Medical			
J3520	•	Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review.		_	[
	Laetrile Amygdalin Vitamin B17	Non Covered: Procedure/service not covered by the Plan.			
J3570		Not subject to pre-service review.	_	_	-
	Unclassified Biologics				
	onclussified biologies	Unlisted: Procedure/service not specifically defined or			
J3590		classified, maybe subject to contract/clinical review. Prior	_	_	_
		Authorization may be required per contract agreement.			
	Unclassified Drug Or Biological Used For Esrd On Dialysis	Unlisted: Procedure/service not specifically defined or			
J3591	Officiassified Drug Of Biological Osed For Esta Off Dialysis	classified, maybe subject to contract/clinical review.	_	_	_
	Injection Human Fibrinagen Concentrate (Fibriga) 1 Mg	MP Criteria: Procedure/service reviewed against Medical			
J7177	Injection Human Fibrinogen Concentrate (Fibryga) 1 Mg				
3/1//		Policy Criteria. Submit for Recommended Clinical Review to	-	-	-
	Laboration III and Filedon Constants Not Other to	avoid post-service review. MP Criteria: Procedure/service reviewed against Medical			
	Injection Human Fibrinogen Concentrate Not Otherwise				
J7178	Specified 1 Mg	Policy Criteria. Submit for Recommended Clinical Review to			_
		avoid post-service review. Prior Authorization may be			
		required per contract agreement.			
	Injection Von Willebrand Factor Complex (Human) Wilate	MP Criteria: Procedure/service reviewed against Medical			
J7183	1 I.U. Vwf:Rco	Policy Criteria. Submit for Recommended Clinical Review to		_	
			4/1/2024		Add effective 04/01/2024
J7192	Factor Viii (Antihemophilic Factor Recombinant) Per I.U.	Unlisted: Procedure/service not specifically defined or			
	Not Otherwise Specified	classified, maybe subject to contract/clinical review.	_	-	-
J7195	Injection Factor Ix (Antihemophilic Factor Recombinant)	Unlisted: Procedure/service not specifically defined or			
7, 133	Per Iu Not Otherwise Specified	classified, maybe subject to contract/clinical review.	-	-	-
J7199	Hemophilia Clotting Factor Not Otherwise Classified	Unlisted: Procedure/service not specifically defined or			
37133		classified, maybe subject to contract/clinical review.	-	-	-
	Methyl Aminolevulinate (Mal) For Topical Administration	MP Criteria: Procedure/service reviewed against Medical			
J7309	16.8% 1 Gram	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Injection Ocriplasmin 0.125 Mg	MP Criteria: Procedure/service reviewed against Medical			
J7316		Policy Criteria. Submit for Recommended Clinical Review to	_	_	<u> </u>
		avoid post-service review.			
	Autologous Cultured Chondrocytes Implant	MP Criteria: Procedures/services reviewed against Medical			
J7330	, · ·	Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review by Carelon.	_	_	[⁻
		arola post scretce review by carcioni			

	Mometasone Furoate Sinus Implant (Sinuva) 10	MP Criteria: Procedure/service reviewed against Medical			
J7402	Micrograms	Policy Criteria. Submit for Recommended Clinical Review to			
	orog.ams	avoid post-service review.	_	_	-
17500	Immunosuppressive Drug Not Otherwise Classified	Unlisted: Procedure/service not specifically defined or			
J7599		classified, maybe subject to contract/clinical review.	_	-	-
	Acetylcysteine Inhalation Solution Compounded Product	EIU: Procedure/service not reimbursed by the Plan. Not			
J7604	Administered Through	subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Levalbuterol Inhalation Solution Compounded Product	EIU: Procedure/service not reimbursed by the Plan. Not			
J7607	Administered Through Dme Concentrated Form 0.5 Mg	subject to pre-service review. Check EIU policy, which is	_	_	-
		one of our Clinical Payment and Coding Policy (CPCP).			
	Albuterol Inhalation Solution Compounded Product	EIU: Procedure/service not reimbursed by the Plan. Not			
J7609	Administered Through Dme Unit Dose 1 Mg	subject to pre-service review. Check EIU policy, which is	_	_	-
		one of our Clinical Payment and Coding Policy (CPCP).			
17610	Albuterol Inhalation Solution Compounded Product	EIU: Procedure/service not reimbursed by the Plan. Not			
J7610	Administered Through Dme Concentrated Form 1 Mg	subject to pre-service review. Check EIU policy, which is	-	-	-
	Levalbuterol Inhalation Solution Compounded Product	one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not			
J7615	Administered Through Dme Unit Dose 0.5 Mg	subject to pre-service review. Check EIU policy, which is			
17013	Administered fillough blile offit bose 0.5 Mg	one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
	Beclomethasone Inhalation Solution Compounded Product				
J7622	Administered Through Dme Unit Dose Form Per Milligram	subject to pre-service review. Check EIU policy, which is			
7.022	Administered finough bline offic bose form fer fining and	one of our Clinical Payment and Coding Policy (CPCP).	-	_	-
	Betamethasone Inhalation Solution Compounded Product	EIU: Procedure/service not reimbursed by the Plan. Not			
J7624	Administered Through Dme Unit Dose Form Per Milligram	subject to pre-service review. Check EIU policy, which is			
		one of our Clinical Payment and Coding Policy (CPCP).			_
	Budesonide Inhalation Solution Compounded Product	EIU: Procedure/service not reimbursed by the Plan. Not			
J7627	Administered Through Dme Unit Dose Form Up To 0.5 Mg	subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Bitolterol Mesylate Inhalation Solution Compounded	EIU: Procedure/service not reimbursed by the Plan. Not			
J7628	Product Administered Through Dme Concentrated Form	subject to pre-service review. Check EIU policy, which is	_	_	-
	Per Milligram	one of our Clinical Payment and Coding Policy (CPCP).			
	Bitolterol Mesylate Inhalation Solution Compounded	EIU: Procedure/service not reimbursed by the Plan. Not			
J7629	Product Administered Through Dme Unit Dose Form Per	subject to pre-service review. Check EIU policy, which is	_	_	_
	Milligram	one of our Clinical Payment and Coding Policy (CPCP).			
17600	Cromolyn Sodium Inhalation Solution Compounded	EIU: Procedure/service not reimbursed by the Plan. Not			
J7632	Product Administered Through	subject to pre-service review. Check EIU policy, which is	_	-	-
	Dudge wide Juhalatian Calutian Consumated Dradust	one of our Clinical Payment and Coding Policy (CPCP).			
17624	Budesonide Inhalation Solution Compounded Product	EIU: Procedure/service not reimbursed by the Plan. Not			
J7634	Administered Through Dme Concentrated Form Per 0.25	subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
	Milligram Atropine Inhalation Solution Compounded Product	EIU: Procedure/service not reimbursed by the Plan. Not			
J7635	Administered Through Dme Concentrated Form Per	subject to pre-service review. Check EIU policy, which is			
17033	Milligram	one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
	Atropine Inhalation Solution Compounded Product	EIU: Procedure/service not reimbursed by the Plan. Not			
J7636	Administered Through Dme Unit Dose Form Per Milligram	subject to pre-service review. Check EIU policy, which is			
	Administrated through only only bose form fer willingfall	one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
		one or our chimear rayment and country for or j.			

	Dexamethasone Inhalation Solution Compounded Product	EIU: Procedure/service not reimbursed by the Plan. Not			
J7637	· · · · · · · · · · · · · · · · · · ·	subject to pre-service review. Check EIU policy, which is			
17057	Administered Through Dme Concentrated Form Per	one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
	Milligram Dexamethasone Inhalation Solution Compounded Product	EIU: Procedure/service not reimbursed by the Plan. Not			
J7638	· ·	subject to pre-service review. Check EIU policy, which is			
17030	Administered Through Dme Unit Dose Form Per Milligram		-	_	-
	Forms about Imbalation Colution Common and Duadout	one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not		+	
J7640	Formoterol Inhalation Solution Compounded Product	· ·			
17040	Administered Through Dme Unit Dose Form 12 Micrograms		-	-	-
	Flusiantide Jaholatian Colution Communication Deadust	one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not			
17.644	Flunisolide Inhalation Solution Compounded Product				
J7641	Administered Through Dme Unit Dose Per Milligram	subject to pre-service review. Check EIU policy, which is	-	-	_
		one of our Clinical Payment and Coding Policy (CPCP).			
17640	Glycopyrrolate Inhalation Solution Compounded Product	EIU: Procedure/service not reimbursed by the Plan. Not			
J7642	Administered Through Dme Concentrated Form Per	subject to pre-service review. Check EIU policy, which is	_	_	_
	Milligram	one of our Clinical Payment and Coding Policy (CPCP).			
	Glycopyrrolate Inhalation Solution Compounded Product	EIU: Procedure/service not reimbursed by the Plan. Not			
J7643	Administered Through Dme Unit Dose Form Per Milligram	subject to pre-service review. Check EIU policy, which is	-	-	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Ipratropium Bromide Inhalation Solution Compounded	EIU: Procedure/service not reimbursed by the Plan. Not			
J7645	Product Administered Through Dme Unit Dose Form Per	subject to pre-service review. Check EIU policy, which is	_	_	_
	Milligram	one of our Clinical Payment and Coding Policy (CPCP).			
	Isoetharine Hcl Inhalation Solution Compounded Product	EIU: Procedure/service not reimbursed by the Plan. Not			
J7647	Administered Through Dme Concentrated Form Per	subject to pre-service review. Check EIU policy, which is	_	_	_
	Milligram	one of our Clinical Payment and Coding Policy (CPCP).			
	Isoetharine Hcl Inhalation Solution Compounded Product	EIU: Procedure/service not reimbursed by the Plan. Not			
J7650	Administered Through Dme Unit Dose Form Per Milligram	subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Isoproterenol Hcl Inhalation Solution Compounded Product	EIU: Procedure/service not reimbursed by the Plan. Not			
J7657	Administered Through Dme Concentrated Form Per	subject to pre-service review. Check EIU policy, which is	_	_	_
	Milligram	one of our Clinical Payment and Coding Policy (CPCP).			
	Isoproterenol Hcl Inhalation Solution Compounded Product	EIU: Procedure/service not reimbursed by the Plan. Not			
J7660	Administered Through Dme Unit Dose Form Per Milligram	subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Metaproterenol Sulfate Inhalation Solution Compounded	EIU: Procedure/service not reimbursed by the Plan. Not			
J7667	Product Concentrated Form Per 10 Milligrams	subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Metaproterenol Sulfate Inhalation Solution Compounded	EIU: Procedure/service not reimbursed by the Plan. Not			
J7670	Product Administered Through Dme Unit Dose Form Per	subject to pre-service review. Check EIU policy, which is	_	_	_
	10 Milligrams	one of our Clinical Payment and Coding Policy (CPCP).			
	Pentamidine Isethionate Inhalation Solution Compounded	EIU: Procedure/service not reimbursed by the Plan. Not			
J7676	Product Administered	subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Terbutaline Sulfate Inhalation Solution Compounded	EIU: Procedure/service not reimbursed by the Plan. Not			
J7680	Product Administered Through Dme Concentrated Form	subject to pre-service review. Check EIU policy, which is	_		_
	Per Milligram	one of our Clinical Payment and Coding Policy (CPCP).			
	Terbutaline Sulfate Inhalation Solution Compounded	EIU: Procedure/service not reimbursed by the Plan. Not			
J7681	Product Administered Through Dme Unit Dose Form Per	subject to pre-service review. Check EIU policy, which is			
	Milligram	one of our Clinical Payment and Coding Policy (CPCP).			
		, , , , , , , , , , , , , , , , , , , ,			

	Triamcinolone Inhalation Solution Compounded Product	EIU: Procedure/service not reimbursed by the Plan. Not			
17602	·				
J7683	Administered Through Dme Concentrated Form Per	subject to pre-service review. Check EIU policy, which is	_	-	-
	Milligram	one of our Clinical Payment and Coding Policy (CPCP).			
	Triamcinolone Inhalation Solution Compounded Product	EIU: Procedure/service not reimbursed by the Plan. Not			
J7684	Administered Through Dme Unit Dose Form Per Milligram	subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Tobramycin Inhalation Solution Compounded Product	EIU: Procedure/service not reimbursed by the Plan. Not			
J7685	Administered Through Dme Unit Dose Form Per 300	subject to pre-service review. Check EIU policy, which is	_	_	_
	Milligrams	one of our Clinical Payment and Coding Policy (CPCP).			
J7699	Noc Drugs Inhalation Solution Administered Through Dme	Unlisted: Procedure/service not specifically defined or			
37033		classified, maybe subject to contract/clinical review.	-	-	_
J7799	Noc Drugs Other Than Inhalation Drugs Administered	Unlisted: Procedure/service not specifically defined or			
17799	Through Dme	classified, maybe subject to contract/clinical review.	_	-	-
J7999	Compounded Drug Not Otherwise Classified	Unlisted: Procedure/service not specifically defined or			
1/999		classified, maybe subject to contract/clinical review.	_	-	-
10.400	Antiemetic Drug Rectal/Suppository Not Otherwise	Unlisted: Procedure/service not specifically defined or			
J8498	Specified	classified, maybe subject to contract/clinical review.	_	-	-
	Prescription Drug Oral Non Chemotherapeutic Nos	Unlisted: Procedure/service not specifically defined or			
J8499	' °	classified, maybe subject to contract/clinical review.	_	_	_
	Antiemetic Drug Oral Not Otherwise Specified	Unlisted: Procedure/service not specifically defined or			
J8597	, i	classified, maybe subject to contract/clinical review.	_	_	_
	Prescription Drug Oral Chemotherapeutic Nos	Unlisted: Procedure/service not specifically defined or			
J8999		classified, maybe subject to contract/clinical review.	_	_	-
	Injection Asparaginase Not Otherwise Specified 10 000	Unlisted: Procedure/service not specifically defined or			
J9020	Units	classified, maybe subject to contract/clinical review.	_	_	_
	Intravesical Instillation Nadofaragene Firadenovec-Vncg Per				
J9029	Therapeutic Dose	Policy Criteria. Submit for Recommended Clinical Review to			
33023	merapeatic bose	avoid post-service review.	_	_	_
	Injection Belantamab Mafodontin-Blmf 0.5 Mg	Non Covered: Procedure/service not covered by the Plan.			
J9037	injection belantamab Marodontin-billi 0.5 Mg		4/1/2024	_	Add effective 04/01/2024
	Injection Copanlisib 1 Mg	Non Covered: Procedure/service not covered by the Plan.	1, 1, 202 1		7 tau en estar e e 1,7 e 2,7 2 e 2 :
J9057	injection Copaniisio 1 ivig	Not subject to pre-service review.	4/1/2024	_	Add effective 04/01/2024
	Initiation Olevations I 10 Ma	Non Covered: Procedure/service not covered by the Plan.	7/ 1/ 2027		71dd effective 04/01/2024
J9285	Injection Olaratumab 10 Mg	· ·	_	_	_
	1	Not subject to pre-service review.			
J9313	Injection Moxetumomab Pasudotox-Tdfk 0.01 Mg	Non Covered: Procedure/service not covered by the Plan.	4/1/2024		Add effective 04/01/2024
	Line of the Late of Land	Not subject to pre-service review. MP Criteria: Procedure/service reviewed against Medical	4/1/2024		Add effective 04/01/2024
	Injection Efgartigimod Alfa-Fcab 2Mg	-			
J9332		Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review. Prior Authorization may be			
		required per contract agreement.			
	Injection Rozanolixizumab-Noli 1 Mg	MP Criteria: Procedure/service reviewed against Medical			
J9333		Policy Criteria. Submit for Recommended Clinical Review to		_	
		avoid post-service review.	2/15/2024		Add effective 02/15/2024
	Injection Efgartigimod Alfa 2 Mg And Hyaluronidase-Qvfc	MP Criteria: Procedure/service reviewed against Medical			
J9334		Policy Criteria. Submit for Recommended Clinical Review to		_	
		avoid post-service review.	2/15/2024		Add effective 02/15/2024

	Injection Retifanlimab-Dlwr 1 Mg	MP Criteria: Procedures/services reviewed against Medical			Moved from PA to
J9345	,,,,,,	Policy Criteria. Submit for Recommended Clinical Review to	1/1/2024		Recommended Clinical Review
		avoid post-service review by Carelon.		_	01/01/2024
	Injection Mosunetuzumab-Axgb 1 Mg	MP Criteria: Procedures/services reviewed against Medical			Moved from PA to
J9350		Policy Criteria. Submit for Recommended Clinical Review to	1/1/2024		Recommended Clinical Review
		avoid post-service review by Carelon.			01/01/2024
	Injection Pozelimab-Bbfg 1 Mg	MP Criteria: Procedure/service reviewed against			
J9376		Medical Policy Criteria. Submit for Recommended			
		Clinical Review to avoid post-service review.	4/15/2024		Add effective 04/01/2024
	Injection Teplizumab-Mzwv 5 Mcg	MP Criteria: Procedure/service reviewed against Medical			
J9381	nystran representative men	Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review.	_	_	_
	Injection Porfimer Sodium 75 Mg	MP Criteria: Procedure/service reviewed against Medical			
J9600	, and the second	Policy Criteria. Submit for Recommended Clinical Review to	_	L	_
		avoid post-service review.			
	Not Otherwise Classified Antineoplastic Drugs	Unlisted: Procedure/service not specifically defined or			
J9999		classified, maybe subject to contract/clinical review. Prior			
19999		Authorization may be required per contract agreement.	-	-	_
	Ultralightweight Wheelchair	MP Criteria: Procedure/service reviewed against Medical			
K0005		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Standard - Weight Frame Motorized/Power Wheelchair	MP Criteria: Procedure/service reviewed against Medical			
K0010		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Standard - Weight Frame Motorized/Power Wheelchair	MP Criteria: Procedure/service reviewed against Medical			
K0011	With Programmable Control Parameters For Speed	Policy Criteria. Submit for Recommended Clinical Review to			
	Adjustment Tremor Dampening Acceleration Control And	avoid post-service review.	_		_
	Braking	MP Criteria: Procedure/service reviewed against Medical			
V0012	Lightweight Portable Motorized/Power Wheelchair	,			
K0012		Policy Criteria. Submit for Recommended Clinical Review to	-	-	_
	Custom Motorized/Power Wheelchair Base	avoid post-service review. MP Criteria: Procedure/service reviewed against Medical			
K0013	custom Motorized/Power Wrieelchair Base	Policy Criteria. Submit for Recommended Clinical Review to			
K0013		avoid post-service review.	_	-	_
	Other Motorized/Power Wheelchair Base	MP Criteria: Procedure/service reviewed against Medical			
K0014	Other Wotonzed/Fower Wheelchair base	Policy Criteria. Submit for Recommended Clinical Review to			
ROOT		avoid post-service review.	_	_	_
	Elevating Footrests Articulating (Telescoping) Each	MP Criteria: Procedure/service reviewed against Medical			
к0053		Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review.	_		_
	Spoke Protectors Each	MP Criteria: Procedure/service reviewed against Medical			
K0065		Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review.	_	Γ	<u></u>

	Wheelchair Component Or Accessory Not Otherwise	MP Criteria: Procedure/service reviewed against Medical			
	Specified	Policy Criteria. Submit for Recommended Clinical Review to			
К0108		avoid post-service review.			
KO100		Unlisted or Undefined: Procedures/services not specifically	-	-	_
		defined or classified, maybe subject to contract/clinical			
		review.			
	Infusion Pump Used For Uninterrupted Parenteral	MP Criteria: Procedure/service reviewed against Medical			
K0455	Administration Of Medication (E. G. Epoprostenol Or	Policy Criteria. Submit for Recommended Clinical Review to	_		
	Treprostinol)	avoid post-service review.			
	Power Operated Vehicle Group 1 Standard Patient Weight	MP Criteria: Procedure/service reviewed against Medical			
К0800	Capacity Up To And Including 300 Pounds	Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review.	_		_
	Power Operated Vehicle Group 1 Heavy Duty Patient	MP Criteria: Procedure/service reviewed against Medical			
K0801	Weight Capacity 301 To 450 Pounds	Policy Criteria. Submit for Recommended Clinical Review to			
	170.8.10 supusity 302 10 130 1 suitus	avoid post-service review.	_	_	_
	Power Operated Vehicle Group 1 Very Heavy Duty Patient	MP Criteria: Procedure/service reviewed against Medical			
к0802	Weight Capacity 451 To 600 Pounds	Policy Criteria. Submit for Recommended Clinical Review to			
	Weight capacity 131 to 550 to and	avoid post-service review.	_	-	_
	Power Operated Vehicle Group 2 Standard Patient Weight	MP Criteria: Procedure/service reviewed against Medical			
к0806	Capacity Up To And Including 300 Pounds	Policy Criteria. Submit for Recommended Clinical Review to			
ROBOO	Capacity op 10 And including 300 Founds	avoid post-service review.	-	-	_
	Power Operated Vehicle Group 2 Heavy Duty Patient	MP Criteria: Procedure/service reviewed against Medical			
К0807		Policy Criteria. Submit for Recommended Clinical Review to			
KU8U7	Weight Capacity 301 To 450 Pounds		_	-	-
	Dawley Or anatod Valriala Crawa 2 Vary Haary Duty Dationt	avoid post-service review. MP Criteria: Procedure/service reviewed against Medical			
V0000					
K0808	Weight Capacity 451 To 600 Pounds	Policy Criteria. Submit for Recommended Clinical Review to	-	-	-
		avoid post-service review.			
	Power Operated Vehicle Not Otherwise Classified	MP Criteria: Procedure/service reviewed against Medical			
		Policy Criteria. Submit for Recommended Clinical Review to			
K0812		avoid post-service review.			
		Unlisted or Undefined: Procedures/services not specifically	_	_	_
		defined or classified, maybe subject to contract/clinical			
		review.			
		MP Criteria: Procedure/service reviewed against Medical			
K0813	Seat And Back Patient Weight Capacity Up To And Including	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	300 Pounds	avoid post-service review.			
	Power Wheelchair Group 1 Standard Portable Captains	MP Criteria: Procedure/service reviewed against Medical			
K0814	Chair Patient Weight Capacity Up To And Including 300	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Pounds	avoid post-service review.			
	Power Wheelchair Group 1 Standard Sling/Solid Seat And	MP Criteria: Procedure/service reviewed against Medical			
K0815	Back Patient Weight Capacity Up To And Including 300	Policy Criteria. Submit for Recommended Clinical Review to	_	L	_
	Pounds	avoid post-service review.			
	Power Wheelchair Group 1 Standard Captains Chair	MP Criteria: Procedure/service reviewed against Medical			
K0816	Patient Weight Capactiy Up To And Including 300 Pounds	Policy Criteria. Submit for Recommended Clinical Review to			
	5 , , ,		_	IT.	<u></u>

	Power Wheelchair Group 2 Standard Portable Sling/Solid	MP Criteria: Procedure/service reviewed against Medical			
K0820	Seat/Back Patient Weight Capacity Up To And Including 300	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Pounds	avoid post-service review.			
	Power Wheelchair Group 2 Standard Portable Captains	MP Criteria: Procedure/service reviewed against Medical			
K0821	Chair Patient Weight Capacity Up To And Including 300	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Pounds	avoid post-service review.			
	Power Wheelchair Group 2 Standard Sling/Solid Seat/Back	MP Criteria: Procedure/service reviewed against Medical			
K0822	Patient Weight Capacity Up To And Including 300 Pounds	Policy Criteria. Submit for Recommended Clinical Review to	_	L	_
		avoid post-service review.			
	Power Wheelchair Group 2 Standard Captains Chair	MP Criteria: Procedure/service reviewed against Medical			
K0823	Patient Weight Capacity Up To And Including 300 Pounds	Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review.	_		_
	Power Wheelchair Group 2 Heavy Duty Sling/Solid	MP Criteria: Procedure/service reviewed against Medical			
K0824	Seat/Back Patient Weight Capacity 301 To 450 Pounds	Policy Criteria. Submit for Recommended Clinical Review to			
	, , , , , , , , , , , , , , , , , , ,	avoid post-service review.	_	_	_
	Power Wheelchair Group 2 Heavy Duty Captains Chair	MP Criteria: Procedure/service reviewed against Medical			
K0825	Patient Weight Capacity 301 To 450 Pounds	Policy Criteria. Submit for Recommended Clinical Review to			
	attent weight capacity ser to lear canas	avoid post-service review.	_	_	-
	Power Wheelchair Group 2 Very Heavy Duty Sling/Solid	MP Criteria: Procedure/service reviewed against Medical			
K0826	Seat/Back Patient Weight Capacity 451 To 600 Pounds	Policy Criteria. Submit for Recommended Clinical Review to			
1.0020	Seaty Back Fatient Weight Capacity 131 10 000 1 04has	avoid post-service review.	_	_	_
	Power Wheelchair Group 2 Very Heavy Duty Captains Chair	MP Criteria: Procedure/service reviewed against Medical			
К0827	Patient Weight Capacity 451 To 600 Pounds	Policy Criteria. Submit for Recommended Clinical Review to			
R0027	Tatient Weight Capacity 431 10 000 1 ounus	avoid post-service review.	-	-	-
	Power Wheelchair Group 2 Extra Heavy Duty Sling/Solid	MP Criteria: Procedure/service reviewed against Medical			
к0828	Seat/Back Patient Weight Capacity 601 Pounds Or More	Policy Criteria. Submit for Recommended Clinical Review to			
R0020	Seaty back Fatient Weight Capacity 001 Founds of More	avoid post-service review.	-	-	_
	Power Wheelchair Group 2 Extra Heavy Duty Captains	MP Criteria: Procedure/service reviewed against Medical			
К0829	Chair Patient Weight Capacity 601 Pounds Or More	Policy Criteria. Submit for Recommended Clinical Review to			
R0023	Chair Patient Weight Capacity 601 Pounds Of More	avoid post-service review.	-	-	-
	Power Wheelchair Group 2 Standard Seat Elevator	MP Criteria: Procedure/service reviewed against Medical			
к0830	· ·	Policy Criteria. Submit for Recommended Clinical Review to			
KU03U	Sling/Solid Seat/Back Patient Weight Capacity Up To And	•	-	-	-
	Including 300 Pounds Power Wheelchair Group 2 Standard Seat Elevator	avoid post-service review. MP Criteria: Procedure/service reviewed against Medical			
V0021	· ·	·			
K0831	Captains Chair Patient Weight Capacity Up To And Including	· ·	-	-	-
	300 Pounds Power Wheelchair Group 2 Standard Single Power Option	avoid post-service review. MP Criteria: Procedure/service reviewed against Medical			
KOOSE					
K0835	Sling/Solid Seat/Back Patient Weight Capacity Up To And	Policy Criteria. Submit for Recommended Clinical Review to	-	-	-
	Including 300 Pounds	avoid post-service review.			
K0836	Power Wheelchair Group 2 Standard Single Power Option	MP Criteria: Procedure/service reviewed against Medical			
	Captains Chair Patient Weight Capacity Up To And Including		_	_	_
	300 Pounds	avoid post-service review.			
	Power Wheelchair Group 2 Heavy Duty Single Power	MP Criteria: Procedure/service reviewed against Medical			
K0837	Option Sling/Solid Seat/Back Patient Weight Capacity 301	Policy Criteria. Submit for Recommended Clinical Review to	_	-	-
	To 450 Pounds	avoid post-service review.			
	Power Wheelchair Group 2 Heavy Duty Single Power	MP Criteria: Procedure/service reviewed against Medical			
K0838	Option Captains Chair Patient Weight Capacity 301 To 450	Policy Criteria. Submit for Recommended Clinical Review to	_	-	-
	Pounds	avoid post-service review.			

	Power Wheelchair Group 2 Very Heavy Duty Single Power	MP Criteria: Procedure/service reviewed against Medical			
K0839	Option Sling/Solid Seat/Back Patient Weight Capacity 451	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	To 600 Pounds	avoid post-service review.			
	Power Wheelchair Group 2 Extra Heavy Duty Single Power	MP Criteria: Procedure/service reviewed against Medical			
K0840	Option Sling/Solid Seat/Back Patient Weight Capacity 601	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Pounds Or More	avoid post-service review.			
	Power Wheelchair Group 2 Standard Multiple Power	MP Criteria: Procedure/service reviewed against Medical			
K0841	Option Sling/Solid Seat/Back Patient Weight Capacity Up To	Policy Criteria. Submit for Recommended Clinical Review to	_		_
	And Including 300 Pounds	avoid post-service review.			
	Power Wheelchair Group 2 Standard Multiple Power	MP Criteria: Procedure/service reviewed against Medical			
K0842	Option Captains Chair Patient Weight Capacity Up To And	Policy Criteria. Submit for Recommended Clinical Review to			
	Including 300 Pounds	avoid post-service review.			
	Power Wheelchair Group 2 Heavy Duty Multiple Power	MP Criteria: Procedure/service reviewed against Medical			
K0843	Option Sling/Solid Seat/Back Patient Weight Capacity 301	Policy Criteria. Submit for Recommended Clinical Review to			
	To 450 Pounds	avoid post-service review.	_		_
	Power Wheelchair Group 3 Standard Sling/Solid Seat/Back	MP Criteria: Procedure/service reviewed against Medical			
K0848	Patient Weight Capacity Up To And Including 300 Pounds	Policy Criteria. Submit for Recommended Clinical Review to			
	The state of the s	avoid post-service review.	-	_	_
	Power Wheelchair Group 3 Standard Captains Chair	MP Criteria: Procedure/service reviewed against Medical			
K0849	Patient Weight Capacity Up To And Including 300 Pounds	Policy Criteria. Submit for Recommended Clinical Review to			
	attend treagne supusity op 107 ma metalling see 1 sames	avoid post-service review.	_	_	-
	Power Wheelchair Group 3 Heavy Duty Sling/Solid	MP Criteria: Procedure/service reviewed against Medical			
K0850	Seat/Back Patient Weight Capacity 301 To 450 Pounds	Policy Criteria. Submit for Recommended Clinical Review to			
	Sear, Back Father Weight capacity 301 To 130 Founds	avoid post-service review.	_	-	_
	Power Wheelchair Group 3 Heavy Duty Captains Chair	MP Criteria: Procedure/service reviewed against Medical			
K0851	Patient Weight Capacity 301 To 450 Pounds	Policy Criteria. Submit for Recommended Clinical Review to			
	Tatient Weight capacity 301 To 430 Tourids	avoid post-service review.	_	-	_
	Power Wheelchair Group 3 Very Heavy Duty Sling/Solid	MP Criteria: Procedure/service reviewed against Medical			
K0852	Seat/Back Patient Weight Capacity 451 To 600 Pounds	Policy Criteria. Submit for Recommended Clinical Review to			
10032	Seaty back Tatient Weight Capacity 451 10 000 Founds	avoid post-service review.	_	-	-
	Power Wheelchair Group 3 Very Heavy Duty Captains Chair	MP Criteria: Procedure/service reviewed against Medical			
K0853	Patient Weight Capacity 451 To 600 Pounds	Policy Criteria. Submit for Recommended Clinical Review to			
10055	Tatient Weight Capacity 431 10 000 1 ounds	avoid post-service review.	_	-	_
	Power Wheelchair Group 3 Extra Heavy Duty Sling/Solid	MP Criteria: Procedure/service reviewed against Medical			
K0854	Seat/Back Patient Weight Capacity 601 Pounds Or More	Policy Criteria. Submit for Recommended Clinical Review to			
K0654	Seat/back Fatient Weight Capacity 601 Founds Of More	avoid post-service review.	_	-	-
	Power Wheelchair Group 3 Extra Heavy Duty Captains	MP Criteria: Procedure/service reviewed against Medical			
K0855		Policy Criteria. Submit for Recommended Clinical Review to			
KU033	Chair Patient Weight Capacity 601 Pounds Or More	· ·	_	-	-
	Dawar Whaalahair Craus 2 Standard Single Dawar Ontion	avoid post-service review.			
KOOEC	Power Wheelchair Group 3 Standard Single Power Option	MP Criteria: Procedure/service reviewed against Medical			
K0856	Sling/Solid Seat/Back Patient Weight Capacity Up To And	Policy Criteria. Submit for Recommended Clinical Review to	-	-	-
	Including 300 Pounds	avoid post-service review.			
K0057	Power Wheelchair Group 3 Standard Single Power Option	MP Criteria: Procedure/service reviewed against Medical			
K0857	Captains Chair Patient Weight Capacity Up To And Including		_	-	-
	300 Pounds	avoid post-service review.			
W0050	Power Wheelchair Group 3 Heavy Duty Single Power	MP Criteria: Procedure/service reviewed against Medical			
K0858	Option Sling/Solid Seat/Back Patient Weight Capacity 301	Policy Criteria. Submit for Recommended Clinical Review to	_	-	_
	To 450 Pounds	avoid post-service review.			

	Davisa Whaalahain Craws 2 Haara Duty Cirala Bawas	MP Criteria: Procedure/service reviewed against Medical		
KOOLO	Power Wheelchair Group 3 Heavy Duty Single Power	·		
K0859	Option Captains Chair Patient Weight Capacity 301 To 450	Policy Criteria. Submit for Recommended Clinical Review to	-	_
	Pounds	avoid post-service review.		
W0000	Power Wheelchair Group 3 Very Heavy Duty Single Power	MP Criteria: Procedure/service reviewed against Medical		
K0860	Option Sling/Solid Seat/Back Patient Weight Capacity 451	Policy Criteria. Submit for Recommended Clinical Review to	_	_
	To 600 Pounds	avoid post-service review.		
	Power Wheelchair Group 3 Standard Multiple Power	MP Criteria: Procedure/service reviewed against Medical		
K0861		Policy Criteria. Submit for Recommended Clinical Review to _	_	_
	And Including 300 Pounds	avoid post-service review.		
	Power Wheelchair Group 3 Heavy Duty Multiple Power	MP Criteria: Procedure/service reviewed against Medical		
K0862	Option Sling/Solid Seat/Back Patient Weight Capacity 301	Policy Criteria. Submit for Recommended Clinical Review to	_	_
	To 450 Pounds	avoid post-service review.		
	Power Wheelchair Group 3 Very Heavy Duty Multiple	MP Criteria: Procedure/service reviewed against Medical		
K0863	Power Option Sling/Solid Seat/Back Patient Weight	Policy Criteria. Submit for Recommended Clinical Review to _	_	_
	Capacity 451 To 600 Pounds	avoid post-service review.		
	Power Wheelchair Group 3 Extra Heavy Duty Multiple	MP Criteria: Procedure/service reviewed against Medical		
K0864	Power Option Sling/Solid Seat/Back Patient Weight	Policy Criteria. Submit for Recommended Clinical Review to _	_	_
	Capacity 601 Pounds Or More	avoid post-service review.		
	Power Wheelchair Group 4 Standard Sling/Solid Seat/Back	MP Criteria: Procedure/service reviewed against Medical		
K0868	Patient Weight Capacity Up To And Including 300 Pounds	Policy Criteria. Submit for Recommended Clinical Review to _	L	_
		avoid post-service review.		
	Power Wheelchair Group 4 Standard Captains Chair	MP Criteria: Procedure/service reviewed against Medical		
K0869	Patient Weight Capacity Up To And Including 300 Pounds	Policy Criteria. Submit for Recommended Clinical Review to		
		avoid post-service review.	_	_
	Power Wheelchair Group 4 Heavy Duty Sling/Solid	MP Criteria: Procedure/service reviewed against Medical		
к0870	Seat/Back Patient Weight Capacity 301 To 450 Pounds	Policy Criteria. Submit for Recommended Clinical Review to		
	, , , , , , , , , , , , , , , , , , ,	avoid post-service review.	<u> </u>	_
	Power Wheelchair Group 4 Very Heavy Duty Sling/Solid	MP Criteria: Procedure/service reviewed against Medical		
K0871	Seat/Back Patient Weight Capacity 451 To 600 Pounds	Policy Criteria. Submit for Recommended Clinical Review to		
		avoid post-service review.	<u> </u>	<u></u>
	Power Wheelchair Group 4 Standard Single Power Option	MP Criteria: Procedure/service reviewed against Medical		
K0877	Sling/Solid Seat/Back Patient Weight Capacity Up To And	Policy Criteria. Submit for Recommended Clinical Review to		
	Including 300 Pounds	avoid post-service review.	_	_
	Power Wheelchair Group 4 Standard Single Power Option	MP Criteria: Procedure/service reviewed against Medical		
K0878		Policy Criteria. Submit for Recommended Clinical Review to		
KOO7 G	300 Pounds	avoid post-service review.	<u> </u> -	-
	Power Wheelchair Group 4 Heavy Duty Single Power	MP Criteria: Procedure/service reviewed against Medical		
К0879	Option Sling/Solid Seat/Back Patient Weight Capacity 301	Policy Criteria. Submit for Recommended Clinical Review to		
K0873	To 450 Pounds	avoid post-service review.	-	_
	Power Wheelchair Group 4 Very Heavy Duty Single Power	MP Criteria: Procedure/service reviewed against Medical		
K0880	Option Sling/Solid Seat/Back Patient Weight 451 To 600	Policy Criteria. Submit for Recommended Clinical Review to		
KUOOU	, , ,	·	-	_
	Pounds Power Wheelshair Group 4 Standard Multiple Power	avoid post-service review. MR Critoria: Procedure/service reviewed against Medical		+
V0004	Power Wheelchair Group 4 Standard Multiple Power	MP Criteria: Procedure/service reviewed against Medical		
K0884		Policy Criteria. Submit for Recommended Clinical Review to	-	-
	And Including 300 Pounds	avoid post-service review.		
KOOOE	Power Wheelchair Group 4 Standard Multiple Power	MP Criteria: Procedure/service reviewed against Medical		
K0885		Policy Criteria. Submit for Recommended Clinical Review to	-	-
	300 Pounds	avoid post-service review.		

	De la Milla de la Caraca Al II a la Dala AA III ala De la la A	NAD Criteria: Dragadura / comica reviewed accirat NA adical		1	
	Power Wheelchair Group 4 Heavy Duty Multiple Power	MP Criteria: Procedure/service reviewed against Medical			
K0886	Option Sling/Solid Seat/Back Patient Weight Capacity 301	Policy Criteria. Submit for Recommended Clinical Review to	_	-	_
	To 450 Pounds	avoid post-service review.			
	Power Wheelchair Group 5 Pediatric Single Power Option	MP Criteria: Procedure/service reviewed against Medical			
K0890	Sling/Solid Seat/Back Patient Weight Capacity Up To And	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Including 125 Pounds	avoid post-service review.			
	Power Wheelchair Group 5 Pediatric Multiple Power	MP Criteria: Procedure/service reviewed against Medical			
K0891	Option Sling/Solid Seat/Back Patient Weight Capacity Up To	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	And Including 125 Pounds	avoid post-service review.			
K0898	Power Wheelchair Not Otherwise Classified	Unlisted: Procedure/service not specifically defined or			
10030		classified, maybe subject to contract/clinical review.	-	-	_
	Power Mobile Device; No Dme Pdac	MP Criteria: Procedure/service reviewed against Medical			
K0899		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Low Frequency Ultrasonic Diathermy Treatment Device For	EIU: Procedure/service not reimbursed by the Plan. Not			
K1004	Home Use	subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Bilateral Hip Knee Ankle Foot Device Powered Includes				
	Pelvic Component Single Or Double Upright(S) Knee Joints	EIU: Procedure/service not reimbursed by the Plan. Not			
K1007	Any Type With Or Without Ankle Joints Any Type Includes	subject to pre-service review. Check EIU policy, which is	_		_
	All Components And Accessories Motors Microprocessors	one of our Clinical Payment and Coding Policy (CPCP).			
	Sensors	, , , , ,			
	Transcutaneous electrical nerve stimulator for electrical	MP Criteria: Procedure/service reviewed against Medical			
K1016	stimulation of the trigeminal nerve	Policy Criteria. Submit for Recommended Clinical Review to			
	summation of the thigenman nerve	· ·	10/15/2023	_	Add effective 10/15/2023
	Monthly supplies for use of device coded at k1016	MP Criteria: Procedure/service reviewed against Medical			
K1017	, стрристи и полити и пол	Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review.	10/15/2023	_	Add effective 10/15/2023
	Oral Device/Appliance Used To Reduce Upper Airway	MP Criteria: Procedure/service reviewed against Medical			
	Collapsibility Without Fixed Mechanical Hinge Custom	Policy Criteria. Submit for Recommended Clinical Review to			
K1027	Fabricated Includes Fitting And Adjustment	avoid post-service review. Prior Authorization may be	_	_	_
	Tabricated includes ritting And Adjustinent	required per contract agreement.			
	External Recharging System For Battery (Internal) For Use	MP Criteria: Procedure/service reviewed against Medical			
K1030	With Implanted Cardiac Contractility Modulation Generator	Policy Criteria. Submit for Recommended Clinical Review to			
K1030	Replacement Only	avoid post-service review.	_	-	-
	Supplies And Accessories (E.G. Transducer) For Low	EIU: Procedure/service not reimbursed by the Plan. Not			
K1036		subject to pre-service review. Check EIU policy, which is			
K1030	Frequency Ultrasonic Diathermy Treatment Device Per	* * *	_	-	-
	Month	one of our Clinical Payment and Coding Policy (CPCP).			
L0999	Addition To Spinal Orthosis Not Otherwise Specified	Unlisted: Procedure/service not specifically defined or	_	_	_
	The wasia Deating Continutions On the site Channel	classified, maybe subject to contract/clinical review.			
	Thoracic Pectus Carinatum Orthosis Sternal	MP Criteria: Procedure/service reviewed against			
L1320	Compression Rigid Circumferential Frame With	Medical Policy Criteria. Submit for Recommended			
11320	Anterior And Posterior Rigid Pads Custom Fabricated	,		-	
		Clinical Review to avoid post-service review.	4/1/2024		Add effective 04/01/2024
	Spinal Orthosis Not Otherwise Specified	Unlisted: Procedure/service not specifically defined or			
L1499	The second secon	classified, maybe subject to contract/clinical review.	-	-	_

	Knee Orthosis Single Upright Thigh And Calf With	MP Criteria: Procedure/service reviewed against Medical			
L1844	Adjustable Flexion And Extension Joint (Unicentric Or	Policy Criteria. Submit for Recommended Clinical Review to			
	Polycentric) Medial-Lateral And Rotation Control With Or	avoid post-service review.	_	_	-
	Without Varus/Valgus Adjustment Custom Fabricated	'			
L2999	Lower Extremity Orthoses Not Otherwise Specified	Unlisted: Procedure/service not specifically defined or			
22333		classified, maybe subject to contract/clinical review.	-	-	-
L3040	Foot Arch Support Removable Premolded Longitudinal	Non Covered: Procedure/service not covered by the Plan.			
13040	Each	Not subject to pre-service review.	-	-	-
L3050	Foot Arch Support Removable Premolded Metatarsal	Non Covered: Procedure/service not covered by the Plan.			
13030	Each	Not subject to pre-service review.	-	-	-
L3060	Foot Arch Support Removable Premolded Longitudinal/	Non Covered: Procedure/service not covered by the Plan.			
L3000	Metatarsal Each	Not subject to pre-service review.	_	_	-
L3649	Orthopedic Shoe Modification Addition Or Transfer Not	Unlisted: Procedure/service not specifically defined or			
L3049	Otherwise Specified	classified, maybe subject to contract/clinical review.	_	_	-
L3999	Upper Limb Orthosis Not Otherwise Specified	Unlisted: Procedure/service not specifically defined or			
13333		classified, maybe subject to contract/clinical review.	_	_	-
	Addition Endoskeletal Knee-Shin System Polycentric	MP Criteria: Procedure/service reviewed against			
L5841	Pneumatic Swing And Stance Phase Control	Medical Policy Criteria. Submit for Recommended			
	, and the second	•	4/1/2024	_	Add effective 04/01/2024
	Addition To Lower Extremity Prosthesis Endoskeletal Knee-	MP Criteria: Procedure/service reviewed against Medical	., _,		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
L5857	Shin System Microprocessor Control Feature Swing Phase	Policy Criteria. Submit for Recommended Clinical Review to			
15057	Only Includes Electronic Sensor(S) Any Type	avoid post-service review.	-	-	-
	Endoskeletal Ankle Foot System Microprocessor Controlled	MP Criteria: Procedure/service reviewed against Medical			
L5973	Feature Dorsiflexion And/Or Plantar Flexion Control	Policy Criteria. Submit for Recommended Clinical Review to			
13973	Includes Power Source	avoid post-service review.	-	-	-
	Addition To Lower Extremity Prostheses Osseointegrated	EIU: Procedure/service not reimbursed by the Plan. Not			
L5991	External Prosthetic Connector	subject to pre-service review. Check EIU policy, which is			
	External Prostrictic Connector	one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
	Lower Extremity Prosthesis Not Otherwise Specified	Unlisted: Procedure/service not specifically defined or			
L5999	Lower Extremity Prostnesis Not Otherwise Specified	classified, maybe subject to contract/clinical review.	_	_	_
	Transcarpal/Metacarpal Or Partial Hand Disarticulation	classified, maybe subject to contract/ cliffical review.			
	Prosthesis External Power Self-Suspended Inner Socket	MP Criteria: Procedure/service reviewed against Medical			
L6026	With Removable Forearm Section Electrodes And Cables	Policy Criteria. Submit for Recommended Clinical Review to			
10020		avoid post-service review.	-	-	-
	Two Batteries Charger Myoelectric Control Of Terminal	avoiu post-service review.			
	Device Excludes Terminal Device(S) Addition To Upper Extremity Prosthesis External Powered	MP Criteria: Procedure/service reviewed against Medical		+	
L6611		Policy Criteria. Submit for Recommended Clinical Review to			
10011	Additional Switch Any Type	avoid post-service review.	-	-	-
	Electric Hand Switch Or Myolelectric Controlled	MP Criteria: Procedure/service reviewed against Medical			
L6880	Independently Articulating Digits Any Grasp Pattern Or	Policy Criteria. Submit for Recommended Clinical Review to			
10000		·	-	-	-
	Combination Of Grasp Patterns Includes Motor(S) Wrist Disarticulation External Power Self-Suspended Inner	avoid post-service review.			
	Socket Removable Forearm Shell Otto Bock Or Equal	MP Criteria: Procedure/service reviewed against Medical			
L6920	· ·	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Switch Cables Two Batteries And One Charger Switch	avoid post-service review.			
	Control Of Terminal Device	ļ.		1	

L6925	Wrist Disarticulation External Power Self-Suspended Inner Socket Removable Forearm Shell Otto Bock Or Equal Electrodes Cables Two Batteries And One Charger Myoelectronic Control Of Terminal Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	-	-
L6930	Below Elbow External Power Self-Suspended Inner Socket Removable Forearm Shell Otto Bock Or Equal Switch Cables Two Batteries And One Charger Switch Control Of Terminal Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	-	-	-
L6935	Below Elbow External Power Self-Suspended Inner Socket Removable Forearm Shell Otto Bock Or Equal Electrodes Cables Two Batteries And One Charger Myoelectronic Control Of Terminal Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	-	-	-
L6940	Elbow Disarticulation External Power Molded Inner Socket Removable Humeral Shell Outside Locking Hinges Forearm Otto Bock Or Equal Switch Cables Two Batteries And One Charger Switch Control Of Terminal Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	-	-	_
L6945	Elbow Disarticulation External Power Molded Inner Socket Removable Humeral Shell Outside Locking Hinges Forearm Otto Bock Or Equal Electrodes Cables Two Batteries And One Charger Myoelectronic Control Of Terminal Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	-	-	-
L6950	Above Elbow External Power Molded Inner Socket Removable Humeral Shell Internal Locking Elbow Forearm Otto Bock Or Equal Switch Cables Two Batteries And One Charger Switch Control Of Terminal Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	-	-	-
L6955	Above Elbow External Power Molded Inner Socket Removable Humeral Shell Internal Locking Elbow Forearm Otto Bock Or Equal Electrodes Cables Two Batteries And One Charger Myoelectronic Control Of Terminal Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	-	-	-
L6960	Shoulder Disarticulation External Power Molded Inner Socket Removable Shoulder Shell Shoulder Bulkhead Humeral Section Mechanical Elbow Forearm Otto Bock Or Equal Switch Cables Two Batteries And One Charger Switch Control Of Terminal Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	-	-	-
L6965	Shoulder Disarticulation External Power Molded Inner Socket Removable Shoulder Shell Shoulder Bulkhead Humeral Section Mechanical Elbow Forearm Otto Bock Or Equal Electrodes Cables Two Batteries And One Charger Myoelectronic Control Of Terminal Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	-	-	-
L6970	Interscapular-Thoracic External Power Molded Inner Socket Removable Shoulder Shell Shoulder Bulkhead Humeral Section Mechanical Elbow Forearm Otto Bock Or Equal Switch Cables Two Batteries And One Charger Switch Control Of Terminal Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	-	-	_

	Interscapular-Thoracic External Power Molded Inner Socket		1	
	·	MP Criteria: Procedure/service reviewed against Medical		
16075	Removable Shoulder Shell Shoulder Bulkhead Humeral	·		
L6975	Section Mechanical Elbow Forearm Otto Bock Or Equal	Policy Criteria. Submit for Recommended Clinical Review to	-	-
	Electrodes Cables Two Batteries And One Charger	avoid post-service review.		
	Myoelectronic Control Of Terminal Device	MP Criteria: Procedure/service reviewed against Medical		
17000	Electric Hand Switch Or Myoelectric Controlled Pediatric			
L7008		Policy Criteria. Submit for Recommended Clinical Review to		_
		avoid post-service review.		
. 7000	Electric Hook Switch Or Myoelectric Controlled Adult	MP Criteria: Procedure/service reviewed against Medical		
L7009		Policy Criteria. Submit for Recommended Clinical Review to	_	-
		avoid post-service review.		
	Prehensile Actuator Switch Controlled	MP Criteria: Procedure/service reviewed against Medical		
L7040		Policy Criteria. Submit for Recommended Clinical Review to	_	_
		avoid post-service review.		
	Electric Hook Switch Or Myoelectric Ontrolled Pediatric	MP Criteria: Procedure/service reviewed against Medical		
L7045		Policy Criteria. Submit for Recommended Clinical Review to	_	-
		avoid post-service review.		
	Electronic Elbow Hosmer Or Equal Switch Controlled	MP Criteria: Procedure/service reviewed against Medical		
L7170		Policy Criteria. Submit for Recommended Clinical Review to	_	-
		avoid post-service review.		
	Electronic Elbow Microprocessor Sequential Control Of	MP Criteria: Procedure/service reviewed against Medical		
L7180	Elbow And Terminal Device	Policy Criteria. Submit for Recommended Clinical Review to _	_	-
		avoid post-service review.		
	Electronic Elbow Microprocessor Simultaneous Control Of	MP Criteria: Procedure/service reviewed against Medical		
L7181	Elbow And Terminal Device	Policy Criteria. Submit for Recommended Clinical Review to _	_	-
		avoid post-service review.		
	Electronic Elbow Adolescent Variety Village Or Equal	MP Criteria: Procedure/service reviewed against Medical		
L7185	Switch Controlled	Policy Criteria. Submit for Recommended Clinical Review to _	_	_
		avoid post-service review.		
	Electronic Elbow Child Variety Village Or Equal Switch	MP Criteria: Procedure/service reviewed against Medical		
L7186	Controlled	Policy Criteria. Submit for Recommended Clinical Review to _	_	_
		avoid post-service review.		
	Electronic Elbow Adolescent Variety Village Or Equal	MP Criteria: Procedure/service reviewed against Medical		
L7190	Myoelectronically Controlled	Policy Criteria. Submit for Recommended Clinical Review to _	_	_
		avoid post-service review.		
	Electronic Elbow Child Variety Village Or Equal	MP Criteria: Procedure/service reviewed against Medical		
L7191	Myoelectronically Controlled	Policy Criteria. Submit for Recommended Clinical Review to _	_	_
		avoid post-service review.		
	Twelve Volt Battery Each	MP Criteria: Procedure/service reviewed against Medical		
L7364		Policy Criteria. Submit for Recommended Clinical Review to _	_	_
		avoid post-service review.		
	Battery Charger Twelve Volt Each	MP Criteria: Procedure/service reviewed against Medical		
L7366	-	Policy Criteria. Submit for Recommended Clinical Review to _	_	
		avoid post-service review.		
17400	Upper Extremity Prosthesis Not Otherwise Specified	Unlisted: Procedure/service not specifically defined or		
L7499		classified, maybe subject to contract/clinical review.	-	-
		. ,		

L8039	Breast Prosthesis Not Otherwise Specified	Unlisted: Procedure/service not specifically defined or			
		classified, maybe subject to contract/clinical review.	-	-	-
L8048	Unspecified Maxillofacial Prosthesis By Report Provided By	Unlisted: Procedure/service not specifically defined or			
200 10	A Non-Physician	classified, maybe subject to contract/clinical review.	-	-	-
L8499	Unlisted Procedure For Miscellaneous Prosthetic Services	Unlisted: Procedure/service not specifically defined or			
20133		classified, maybe subject to contract/clinical review.	-	-	-
	Implantable Breast Prosthesis Silicone Or Equal	MP Criteria: Procedures/services reviewed against Medical			
L8600		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by BCBS.			
	Injectable Bulking Agent Collagen Implant Urinary Tract 2.	EIU: Procedure/service not reimbursed by the Plan. Not			
L8603	5 MI Syringe Includes Shipping And Necessary Supplies	subject to pre-service review. Check EIU policy, which is		_	
		one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024		Add effective 05/15/2024
	Injectable Bulking Agent Dextranomer/Hyaluronic Acid	MP Criteria: Procedure/service reviewed against Medical			
L8604	Copolymer Implant Urinary Tract 1 MI Includes Shipping	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	And Necessary Supplies	avoid post-service review.			
	Injectable Bulking Agent Dextranomer/Hyaluronic Acid	EIU: Procedure/service not reimbursed by the Plan. Not			
L8605	Copolymer Implant Anal Canal 1 MI Includes Shipping And	subject to pre-service review. Check EIU policy, which is	_	_	_
	Necessary Supplies	one of our Clinical Payment and Coding Policy (CPCP).			
	Injectable Bulking Agent Synthetic Implant Urinary Tract 1	MP Criteria: Procedure/service reviewed against Medical			
L8606	MI Syringe Includes Shipping And Necessary Supplies	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Miscellaneous External Component Supply Or Accessory For	EIU: Procedure/service not reimbursed by the Plan. Not			
L8608	Use With The Argus Ii Retinal Prosthesis System	subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Aqueous Shunt	MP Criteria: Procedure/service reviewed against Medical			
L8612		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Cochlear Device Includes All Internal And External	MP Criteria: Procedure/service reviewed against Medical			
10614	Components	Policy Criteria. Submit for Recommended Clinical Review to			
L8614		avoid post-service review. Prior Authorization may be	-	-	-
		required per contract agreement.			
	Headset/Headpiece For Use With Cochlear Implant Device	MP Criteria: Procedure/service reviewed against Medical			
10015	Replacement	Policy Criteria. Submit for Recommended Clinical Review to			
L8615		avoid post-service review. Prior Authorization may be	-	-	-
		required per contract agreement.			
	Microphone For Use With Cochlear Implant Device	MP Criteria: Procedure/service reviewed against Medical			
19616	Replacement	Policy Criteria. Submit for Recommended Clinical Review to			
L8616		avoid post-service review. Prior Authorization may be	-	-	-
		required per contract agreement.			
	Transmitting Coil For Use With Cochlear Implant Device	MP Criteria: Procedure/service reviewed against Medical			
10017	Replacement	Policy Criteria. Submit for Recommended Clinical Review to			
L8617		avoid post-service review. Prior Authorization may be	-	-	-
		required per contract agreement.			
	Transmitter Cable For Use With Cochlear Implant Device Or	MP Criteria: Procedure/service reviewed against Medical			
10010	Auditory Osseointegrated Device Replacement	Policy Criteria. Submit for Recommended Clinical Review to			
L8618		avoid post-service review. Prior Authorization may be	-	-	-
		required per contract agreement.			

		AAD Collected December 1 and 1 and 1 and 1 and 1 and 1 and 1		
	Cochlear Implant External Speech Processor And Controller	MP Criteria: Procedure/service reviewed against Medical		
L8619	Integrated System Replacement	Policy Criteria. Submit for Recommended Clinical Review to		
20013		avoid post-service review. Prior Authorization may be	-	-
		required per contract agreement.		
	Zinc Air Battery For Use With Cochlear Implant Device And	MP Criteria: Procedure/service reviewed against Medical		
10004	Auditory Osseointegrated Sound Processors Replacement	Policy Criteria. Submit for Recommended Clinical Review to		
L8621	Each	avoid post-service review. Prior Authorization may be	_	_
	200.1	required per contract agreement.		
	Alkaline Battery For Use With Cochlear Implant Device Any	MP Criteria: Procedure/service reviewed against Medical		
	Size Replacement Each	Policy Criteria. Submit for Recommended Clinical Review to		
L8622	Size Replacement Lacii	avoid post-service review. Prior Authorization may be	_	_
		required per contract agreement.		
	Lithium Ion Pottony For Use With Cooklear Implent Davise	MP Criteria: Procedure/service reviewed against Medical		
	Lithium Ion Battery For Use With Cochlear Implant Device	· ·		
L8623	Speech Processor Other Than Ear Level Replacement Each	Policy Criteria. Submit for Recommended Clinical Review to		
		avoid post-service review. Prior Authorization may be	_	<u> </u>
		required per contract agreement.		
	Lithium Ion Battery For Use With Cochlear Implant Or	MP Criteria: Procedure/service reviewed against Medical		
L8624	Auditory Osseointegrated Device Speech Processor Ear	Policy Criteria. Submit for Recommended Clinical Review to		
10024	Level Replacement Each	avoid post-service review. Prior Authorization may be	-	-
		required per contract agreement.		
	Cochlear Implant External Speech Processor Component	MP Criteria: Procedure/service reviewed against Medical		
	Replacement	Policy Criteria. Submit for Recommended Clinical Review to		
L8627	<u>'</u>	avoid post-service review. Prior Authorization may be	-	_
		required per contract agreement.		
	Cochlear Implant External Controller Component	MP Criteria: Procedure/service reviewed against Medical		
	Replacement	Policy Criteria. Submit for Recommended Clinical Review to		
L8628	Replacement	avoid post-service review. Prior Authorization may be	_	_
	Transmitting Cail And Cable Integrated For Use With	required per contract agreement. MP Criteria: Procedure/service reviewed against Medical		
	Transmitting Coil And Cable Integrated For Use With	·		
L8629	Cochlear Implant Device Replacement	Policy Criteria. Submit for Recommended Clinical Review to		
		avoid post-service review. Prior Authorization may be		
		required per contract agreement.		
	Electrical Stimulator Supplies (External) For Use With	MP Criteria: Procedure/service reviewed against Medical		
L8678	Implantable Neurostimulator Per Month	Policy Criteria. Submit for Recommended Clinical Review to	_	_
		avoid post-service review.		
	Implantable Neurostimulator Pulse Generator Any Type	MP Criteria: Procedure/service reviewed against Medical		
L8679		Policy Criteria. Submit for Recommended Clinical Review to _	_	_
		avoid post-service review.		
	Implantable Neurostimulator Electrode Each	MP Criteria: Procedure/service reviewed against Medical		
L8680		Policy Criteria. Submit for Recommended Clinical Review to		
		avoid post-service review.	_	<u> </u>
	Patient Programmer (External) For Use With Implantable	MP Criteria: Procedure/service reviewed against Medical		
L8681	Programmable Neurostimulator Pulse Generator	Policy Criteria. Submit for Recommended Clinical Review to		
	Replacement Only	avoid post-service review.	-	-
	Implantable Neurostimulator Radiofrequency Receiver	MP Criteria: Procedure/service reviewed against Medical	-	+
L8682	implantable Neurostiniulator Radioffequency Receiver	· ·		
LOUOZ		Policy Criteria. Submit for Recommended Clinical Review to	-	-
		avoid post-service review.		

	Radiofrequency Transmitter (External) For Use With	MP Criteria: Procedure/service reviewed against Medical			
L8683	Implantable Neurostimulator Radiofrequency Receiver	Policy Criteria. Submit for Recommended Clinical Review to _	_	_	_
		avoid post-service review.			
	Implantable Neurostimulator Pulse Generator Single Array	MP Criteria: Procedure/service reviewed against Medical			
L8685	Rechargeable Includes Extension	Policy Criteria. Submit for Recommended Clinical Review to _		_	_
		avoid post-service review.			
	Implantable Neurostimulator Pulse Generator Single Array	MP Criteria: Procedure/service reviewed against Medical			
L8686	Non-Rechargeable Includes Extension	Policy Criteria. Submit for Recommended Clinical Review to			
	Tron neonal geaste molades Extension	avoid post-service review.	-	-	_
	Implantable Neurostimulator Pulse Generator Dual Array	MP Criteria: Procedure/service reviewed against Medical			
L8687	Rechargeable Includes Extension	Policy Criteria. Submit for Recommended Clinical Review to			
20007	The charge and a morage a section of	avoid post-service review.		_	-
	Implantable Neurostimulator Pulse Generator Dual Array	MP Criteria: Procedure/service reviewed against Medical			
L8688	Non-Rechargeable Includes Extension	Policy Criteria. Submit for Recommended Clinical Review to			
18000	Non-Rechargeable includes extension	avoid post-service review.	-	-	_
	Futornal Decharging Custom For Dettony (Internal) For Lice	MP Criteria: Procedure/service reviewed against Medical			
10000	External Recharging System For Battery (Internal) For Use				
L8689	With Implantable Neurostimulator Replacement Only	Policy Criteria. Submit for Recommended Clinical Review to	-	-	_
		avoid post-service review.			
	Auditory Osseointegrated Device Includes All Internal And	MP Criteria: Procedure/service reviewed against Medical			
L8690	External Components	Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review. Prior Authorization may be		-	-
		required per contract agreement.			
	Auditory Osseointegrated Device External Sound Processor	MP Criteria: Procedure/service reviewed against Medical			
L8691	Excludes Transducer/Actuator Replacement Only Each	Policy Criteria. Submit for Recommended Clinical Review to			
18031		avoid post-service review. Prior Authorization may be	-	-	_
		required per contract agreement.			
	Auditory Osseointegrated Device Abutment Any Length	MP Criteria: Procedure/service reviewed against Medical			
10000	Replacement Only	Policy Criteria. Submit for Recommended Clinical Review to			
L8693		avoid post-service review. Prior Authorization may be	-	_	_
		required per contract agreement.			
	External Recharging System For Battery (External) For Use	MP Criteria: Procedure/service reviewed against Medical			
L8695	With Implantable Neurostimulator Replacement Only	Policy Criteria. Submit for Recommended Clinical Review to			
	The mipaness real section deposes ment emp	avoid post-service review.		-	-
	Prosthetic Implant Not Otherwise Specified	Unlisted: Procedure/service not specifically defined or			
L8699	Trostrictic implant Not otherwise specified	classified, maybe subject to contract/clinical review.	_	_	_
	Powered Upper Extremity Range Of Motion Assist Device				
		MP Criteria: Procedure/service reviewed against Medical			
L8701	Elbow Wrist Hand With Single Or Double Upright(S)	Policy Criteria. Submit for Recommended Clinical Review to _		_	_
	Includes Microprocessor Sensors All Components And	avoid post-service review.			
	Accessories Custom Fabricated				
	Powered Upper Extremity Range Of Motion Assist Device	MP Criteria: Procedure/service reviewed against Medical			
L8702	Elbow Wrist Hand Finger Single Or Double Upright(S)	Policy Criteria. Submit for Recommended Clinical Review to			
	Includes Microprocessor Sensors All Components And	avoid post-service review.	-	-	-
	Accessories Custom Fabricated				
M0075	Cellular Therapy	Non Covered: Procedure/service not covered by the Plan.			
		Not subject to pre-service review.	-	-	

	Prolotherapy	EIU: Procedure/service not reimbursed by the Plan. Not			
140076	Prolottierapy	· ·			
M0076		subject to pre-service review. Check EIU policy, which is	_	-	-
		one of our Clinical Payment and Coding Policy (CPCP).			
	Intravenous Infusion Or Subcutaneous Injection Casirivimab	EIU: Procedure/service not reimbursed by the Plan. Not			
M0240	And Imdevimab Includes Infusion Or Injection And Post	subject to pre-service review. Check EIU policy, which is			
14102-40	Administration Monitoring Subsequent Repeat Doses	one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
		one of our clinical rayment and coding rolley (crer).			
	Intravenous Infusion Or Subcutaneous Injection Casirivimab				
	And Imdevimab Includes Infusion Or Injection And Post				
	Administration Monitoring In The Home Or Residence This	EIU: Procedure/service not reimbursed by the Plan. Not			
M0241	Includes A Beneficiary'S Home That Has Been Made Provider	subject to pre-service review. Check EIU policy, which is			
	Based To The Hospital During The Covid-19 Public Health	one of our Clinical Payment and Coding Policy (CPCP).		Г	
	Emergency Subsequent Repeat Doses	, , , ,			
	Emergency Subsequent Repeat 20363				
	Intravenous Infusion Or Subcutaneous Injection Casirivimab	EIU: Procedure/service not reimbursed by the Plan. Not			
M0243	And Imdevimab Includes Infusion Or Injection And Post	subject to pre-service review. Check EIU policy, which is			
	Administration Monitoring	one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
	Intravenous Infusion Or Subcutaneous Injection Casirivimab	, , , ,			
	And Imdevimab Includes Infusion Or Injection And Post				
	Administration Monitoring In The Home Or Residence; This	EIU: Procedure/service not reimbursed by the Plan. Not			
M0244	·	subject to pre-service review. Check EIU policy, which is	_	_	_
	Includes A Beneficiary'S Home That Has Been Made Provider	one of our Clinical Payment and Coding Policy (CPCP).			
	Based To The Hospital During The Covid-19 Public Health				
	Intravenous Infusion Bamlanivimab And Etesevimab	EIU: Procedure/service not reimbursed by the Plan. Not			
M0245					
IVIU245	Includes Infusion And Post Administration Monitoring	subject to pre-service review. Check EIU policy, which is	-	-	-
	Laboration and the Company of the Analysis of the Company of the C	one of our Clinical Payment and Coding Policy (CPCP).			
	Intravenous Infusion Bamlanivimab And Etesevimab	FILL Board on from the color of the Black Not			
	Includes Infusion And Post Administration Monitoring In The				
M0246	Home Or Residence; This Includes A Beneficiary'S Home	subject to pre-service review. Check EIU policy, which is	_	_	_
	That Has Been Made Provider Based To The Hospital During	one of our Clinical Payment and Coding Policy (CPCP).			
	The Covid 19 Public Health Emergency				
	Hair Analysis (Excluding Arsenic)	MP Criteria: Procedure/service reviewed against Medical			
P2031		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Platelet Rich Plasma Each Unit	EIU: Procedure/service not reimbursed by the Plan. Not			
P9020		subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Blood Component Or Product Not Otherwise Classified	Non Covered: Procedure/service not covered by the Plan.			
		Not subject to pre-service review.			
P9099		Unlisted or Undefined: Procedures/services not specifically	_		
		defined or classified, maybe subject to contract/clinical			
		review.			
	Injection Casirivimab And Imdevimab 600 Mg	EIU: Procedure/service not reimbursed by the Plan. Not			
Q0240		subject to pre-service review. Check EIU policy, which is			
		one of our Clinical Payment and Coding Policy (CPCP).	_	_	
		22 2. 23. Chinear ajchic and county to they for of j.			

	Injection Casirivimab And Imdevimab 2400 Mg	EIU: Procedure/service not reimbursed by the Plan. Not			
Q0243		subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Injection Casirivimab And Imdevimab 1200 Mg	EIU: Procedure/service not reimbursed by the Plan. Not			
Q0244		subject to pre-service review. Check EIU policy, which is	_		_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Injection Bamlanivimab And Etesevimab 2100 Mg	EIU: Procedure/service not reimbursed by the Plan. Not			
Q0245		subject to pre-service review. Check EIU policy, which is			
Q02.0		one of our Clinical Payment and Coding Policy (CPCP).	-	_	_
	Miscellaneous Supply Or Accessory For Use With An External				
Q0507			_	_	_
	Ventricular Assist Device	classified, maybe subject to contract/clinical review.			
Q0508	Miscellaneous Supply Or Accessory For Use With An	Unlisted: Procedure/service not specifically defined or			_
	Implanted Ventricular Assist Device	classified, maybe subject to contract/clinical review.	_	_	
	Miscellaneous Supply Or Accessory For Use With Any	Unlisted: Procedure/service not specifically defined or			
Q0509	Implanted Ventricular Assist Device For Which Payment Was	classified, maybe subject to contract/clinical review.	_	_	_
	Not Made Under Medicare Part A				
Q0510	Pharmacy Supply Fee For Initial Immunosuppressive Drug(S)	Non Covered: Procedure/service not covered by the Plan.			
Q0310	First Month Following Transplant	Not subject to pre-service review.	-	-	_
	Pharmacy Supply Fee For Oral Anti-Cancer Oral Anti-Emetic	No. Co. and Board of a longitude of the Black			
Q0511	Or Immunosuppressive Drug(S); For The First Prescription In	Non Covered: Procedure/service not covered by the Plan.			
	A 30-Day Period	Not subject to pre-service review.	_	_	_
	Pharmacy Supply Fee For Oral Anti-Cancer Oral Anti-Emetic				
Q0512	Or Immunosuppressive Drug(S); For A Subsequent	Non Covered: Procedure/service not covered by the Plan.			
Q0312	Prescription In A 30-Day Period	Not subject to pre-service review.	-	-	_
	Injection Radiesse 0.1 MI	MP Criteria: Procedure/service reviewed against Medical			
Q2026	injection radiesse 0.1 Wil	Policy Criteria. Submit for Recommended Clinical Review to			
Q2020		·	_	-	-
	Intention Couleton O.F.M.	avoid post-service review. MP Criteria: Procedure/service reviewed against Medical			
	Injection Sculptra 0.5 Mg	-			
Q2028		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
Q2039	Influenza Virus Vaccine Not Otherwise Specified	Unlisted: Procedure/service not specifically defined or			
		classified, maybe subject to contract/clinical review.	-	-	_
	Axicabtagene Ciloleucel Up To 200 Million Autologous Anti-	MP Criteria: Procedure/service reviewed against Medical			
Q2041	Cd19 Car Positive Viable T Cells Including Leukapheresis And	Policy Criteria. Submit for Recommended Clinical Review to			
Q2041	Dose Preparation Procedures Per Therapeutic Dose	avoid post-service review. Prior Authorization may be	-	-	-
		required per contract agreement.			
	Tisagenlecleucel Up To 600 Million Car-Positive Viable T	MP Criteria: Procedure/service reviewed against Medical			
	Cells Including Leukapheresis And Dose Preparation	Policy Criteria. Submit for Recommended Clinical Review to			
Q2042	Procedures Per Therapeutic Dose	avoid post-service review. Prior Authorization may be	_	_	_
	Troccaures Fer merapeatic bose	required per contract agreement.			
	Injection Doxorubicin Hydrochloride Liposomal	New Comments Durandous / comments and account of the Alexander			
Q2049		· ·	4/1/2024		Add offortive 04/01/2024
	Imported Lipodox 10 Mg	Plan. Not subject to pre-service review.			Add effective 04/01/2024
	Injection Doxorubicin Hydrochloride Liposomal Not	Unlisted: Procedure/service not specifically defined or			
Q2050	Otherwise Specified 10Mg	classified, maybe subject to contract/clinical review. Prior			
Q2030		Authorization may be required per contract agreement.	-	-	_
		Authorization may be required per contract agreement.			

	Services Supplies And Accessories Used In The Home For	Non Covered: Procedure/service not covered by the Plan.			
Q2052	The Administration Of Intravenous Immune Globulin (Ivig)	Not subject to pre-service review.	_	_	_
	Brexucabtagene Autoleucel Up To 200 Million Autologous	MP Criteria: Procedure/service reviewed against Medical			
	Anti-Cd19 Car Positive Viable T Cells Including	Policy Criteria. Submit for Recommended Clinical Review to			
Q2053	Leukapheresis And Dose Preparation Procedures Per	avoid post-service review. Prior Authorization may be	_	_	_
	Therapeutic Dose	required per contract agreement.			
	Lisocabtagene Maraleucel Up To 110 Million Autologous	MP Criteria: Procedure/service reviewed against Medical			
	Anti-Cd19 Car-Positive Viable T Cells Including	Policy Criteria. Submit for Recommended Clinical Review to			
Q2054	Leukapheresis And Dose Preparation Procedures Per	avoid post-service review. Prior Authorization may be	_	_	_
	Therapeutic Dose	required per contract agreement.			
	Idecabtagene Vicleucel Up To 460 Million Autologous B-Cell	MP Criteria: Procedure/service reviewed against Medical			
	Maturation Antigen (Bcma) Directed Car-Positive T Cells	Policy Criteria. Submit for Recommended Clinical Review to			
Q2055	Including Leukapheresis And Dose Preparation Procedures	avoid post-service review. Prior Authorization may be	_	_	_
	Per Therapeutic Dose	required per contract agreement.			
	Ciltacabtagene Autoleucel Up To 100 Million Autologous B-	MP Criteria: Procedure/service reviewed against Medical			
00056	Cell Maturation Antigen (Bcma) Directed Car-Positive T Cells	Policy Criteria. Submit for Recommended Clinical Review to			
Q2056	Including Leukapheresis And Dose Preparation Procedures	avoid post-service review. Prior Authorization may be	_	_	_
	Per Therapeutic Dose	required per contract agreement.			
	Radioelements For Brachytherapy Any Type Each	MP Criteria: Procedures/services reviewed against Medical			
Q3001		Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review by Carelon.			
0.4050	Cast Supplies For Unlisted Types And Materials Of Casts	Unlisted: Procedure/service not specifically defined or			
Q4050		classified, maybe subject to contract/clinical review.	_	-	-
Q4051	Splint Supplies Miscellaneous (Includes Thermoplastics	Unlisted: Procedure/service not specifically defined or			
Q4031	Strapping Fasteners Padding And Other Supplies)	classified, maybe subject to contract/clinical review.	_	-	-
	Drug Or Biological Not Otherwise Classified Part B Drug	Non Covered: Procedure/service not covered by the Plan.			
	Competitive Acquisition Program (Cap)	Not subject to pre-service review.			
Q4082		Unlisted or Undefined: Procedures/services not specifically	_	_	_
		defined or classified, maybe subject to contract/clinical			
		review.			
	Skin Substitute Not Otherwise Specified	MP Criteria: Procedure/service reviewed against Medical			
		Policy Criteria. Submit for Recommended Clinical Review to			
Q4100		avoid post-service review.			
Q4100		Unlisted or Undefined: Procedures/services not specifically	_	-	_
		defined or classified, maybe subject to contract/clinical			
		review.			
	Apligraf Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical			
Q4101		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Oasis Wound Matrix Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical			
Q4102		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Oasis Burn Matrix Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4103		subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			

	Integra Bilayer Matrix Wound Dressing (Bmwd) Per Square	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4104	Centimeter	subject to pre-service review. Check EIU policy, which is			
Q.20.	Continuence	one of our Clinical Payment and Coding Policy (CPCP).	_	_	-
	Integra Dermal Regeneration Template (Drt) Or Integra	MP Criteria: Procedure/service reviewed against Medical			
Q4105	Omnigraft Dermal Regeneration Matrix Per Square	Policy Criteria. Submit for Recommended Clinical Review to			
Q1103	Centimeter	avoid post-service review.	_	-	-
	Dermagraft Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical			
Q4106	Dermagnant Fer Square Centimeter	Policy Criteria. Submit for Recommended Clinical Review to			
Q4100		avoid post-service review.	-	-	-
	Graftjacket Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical			
Q4107	Granjacket Fer Square Centimeter	Policy Criteria. Submit for Recommended Clinical Review to			
Q4107		, ·	_	_	-
	Integra Matrix Per Square Centimeter	avoid post-service review. MP Criteria: Procedure/service reviewed against Medical			
04100	integra Matrix Per Square Centimeter	Policy Criteria. Submit for Recommended Clinical Review to			
Q4108		•	_	_	-
	Drimatriy Day Caylara Continuator	avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not			
04110	Primatrix Per Square Centimeter	· ·			
Q4110		subject to pre-service review. Check EIU policy, which is	_	-	-
	Community Box Community Continued to	one of our Clinical Payment and Coding Policy (CPCP).			
04444	Gammagraft Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4111		subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Cymetra Injectable 1Cc	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4112		subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Graftjacket Xpress Injectable 1Cc	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4113		subject to pre-service review. Check EIU policy, which is	_	_	-
		one of our Clinical Payment and Coding Policy (CPCP).			
	Integra Flowable Wound Matrix Injectable 1Cc	MP Criteria: Procedure/service reviewed against Medical			
Q4114		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Alloskin Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4115		subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Alloderm Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical			
Q4116		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Hyalomatrix Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4117		subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Matristem Micromatrix 1 Mg	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4118		subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Theraskin Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4121		subject to pre-service review. Check EIU policy, which is			
		one of our Clinical Payment and Coding Policy (CPCP).	_		
	Dermacell Dermacell Awm Or Dermacell Awm Porous Per	MP Criteria: Procedure/service reviewed against Medical			
Q4122	Square Centimeter	Policy Criteria. Submit for Recommended Clinical Review to			
,		avoid post-service review.	_	_	-
		a total post service review.			-!

	Allestin Dt. Den Courses Continueton	FILL Procedure/consider not reimbursed by the Plan Not			
0.4400	Alloskin Rt Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4123		subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Oasis Ultra Tri-Layer Wound Matrix Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4124		subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Arthroflex Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4125		subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Memoderm Dermaspan Tranzgraft Or Integuply Per	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4126	Square Centimeter	subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Talymed Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4127		subject to pre-service review. Check EIU policy, which is	_		_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Flex Hd Or Allopatch Hd Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical			
Q4128		Policy Criteria. Submit for Recommended Clinical Review to			
1		avoid post-service review.	_	_	_
	Strattice Tm Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4130		subject to pre-service review. Check EIU policy, which is			
		one of our Clinical Payment and Coding Policy (CPCP).	_	_	-
	Grafix Core And Grafixpl Core Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical			
Q4132	Grank core in a Grankpi core i er square certaineter	Policy Criteria. Submit for Recommended Clinical Review to			
Q+132		avoid post-service review.	_	-	_
	Grafix Prime Grafixpl Prime Stravix And Stravixpl Per	MP Criteria: Procedure/service reviewed against Medical			
Q4133	Square Centimeter	Policy Criteria. Submit for Recommended Clinical Review to			
Q+155	Square Centimeter	avoid post-service review.	_	-	_
	Hmatrix Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4134	Timatrix Fer Square Centimeter	subject to pre-service review. Check EIU policy, which is			
Q4134		one of our Clinical Payment and Coding Policy (CPCP).	_	-	_
	Madialia Dar Causas Castinantas	EIU: Procedure/service not reimbursed by the Plan. Not			
04135	Mediskin Per Square Centimeter				
Q4135		subject to pre-service review. Check EIU policy, which is	_	-	_
	5.0.0.0.0.0	one of our Clinical Payment and Coding Policy (CPCP).			
0.4406	Ez-Derm Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4136		subject to pre-service review. Check EIU policy, which is	_	-	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Amnioexcel Amnioexcel Plus Or Biodexcel Per Square	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4137	Centimeter	subject to pre-service review. Check EIU policy, which is	_	-	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Biodfence Dryflex Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4138		subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Amniomatrix Or Biodmatrix Injectable 1 Cc	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4139		subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Biodfence Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4140		subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			

	Alloskin Ac Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4141		subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Xcm Biologic Tissue Matrix Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4142		subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Repriza Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4143		subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Epifix Injectable 1 Mg	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4145		subject to pre-service review. Check EIU policy, which is			
		one of our Clinical Payment and Coding Policy (CPCP).	_		_
	Tensix Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4146		subject to pre-service review. Check EIU policy, which is			
,		one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
	Architect Architect Px Or Architect Fx Extracellular Matrix	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4147	Per Square Centimeter	subject to pre-service review. Check EIU policy, which is			
Q+1+7	Tel Square centimeter	one of our Clinical Payment and Coding Policy (CPCP).	_	-	_
	Neox Cord 1K Neox Cord Rt Or Clarix Cord 1K Per Square	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4148	· · · · · · · · · · · · · · · · · · ·	subject to pre-service review. Check EIU policy, which is			
Q4148	Centimeter		_	-	_
	Free Harris 0.4 Co	one of our Clinical Payment and Coding Policy (CPCP).			
0.44.40	Excellagen 0.1 Cc	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4149		subject to pre-service review. Check EIU policy, which is	_	-	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Allowrap Ds Or Dry Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4150		subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Amnioband Or Guardian Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical			
Q4151		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Dermapure Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4152		subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Dermavest And Plurivest Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4153		subject to pre-service review. Check EIU policy, which is			
		one of our Clinical Payment and Coding Policy (CPCP).			
	Biovance Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical			
Q4154	·	Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review.	_	_	_
	Neoxflo Or Clarixflo 1 Mg	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4155		subject to pre-service review. Check EIU policy, which is			
Q1133		one of our Clinical Payment and Coding Policy (CPCP).	_	-	_
	Neox 100 Or Clarix 100 Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4156	11COX 100 OF CIATIX 100 FET SQUARE CERTIFICATE	subject to pre-service review. Check EIU policy, which is			
Q+130		one of our Clinical Payment and Coding Policy (CPCP).	-	-	_
	Positolon Por Square Continuetor	, , , ,			
04157	Revitalon Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4157		subject to pre-service review. Check EIU policy, which is	-	-	-
		one of our Clinical Payment and Coding Policy (CPCP).			

	Kerecis Omega3 Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not		
Q4158	nereus omegas ver square centimeter	subject to pre-service review. Check EIU policy, which is		
Q1130		one of our Clinical Payment and Coding Policy (CPCP).	-	-
	Affinity Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical		
Q4159	Annity Tel Square centimeter	Policy Criteria. Submit for Recommended Clinical Review to		
Q 1233		avoid post-service review.	-	-
	Nushield Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not		
Q4160	Nusifield Tel Square Certifficter	subject to pre-service review. Check EIU policy, which is		
Q4100		one of our Clinical Payment and Coding Policy (CPCP).	-	-
	Bio-Connekt Wound Matrix Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not		
Q4161	Bio-Connekt Wound Matrix Per Square Centimeter	subject to pre-service review. Check EIU policy, which is		
Q4101		one of our Clinical Payment and Coding Policy (CPCP).	-	-
	Woundex Flow Bioskin Flow 0.5 Cc	EIU: Procedure/service not reimbursed by the Plan. Not		
Q4162	Wouldex Flow Bloskill Flow 0.5 CC	subject to pre-service review. Check EIU policy, which is		
Q4102			-	-
	Maunday Biaskin Par Sayara Continuator	one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not		
Q4163	Woundex Bioskin Per Square Centimeter			
Q4103		subject to pre-service review. Check EIU policy, which is	-	-
	Haliaall Day Cayraya Cayrtiga atau	one of our Clinical Payment and Coding Policy (CPCP).		
04464	Helicoll Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not		
Q4164		subject to pre-service review. Check EIU policy, which is	-	-
		one of our Clinical Payment and Coding Policy (CPCP).		
	Keramatrix Or Kerasorb Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not		
Q4165		subject to pre-service review. Check EIU policy, which is	_	-
		one of our Clinical Payment and Coding Policy (CPCP).		
	Cytal Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not		
Q4166		subject to pre-service review. Check EIU policy, which is	_	-
		one of our Clinical Payment and Coding Policy (CPCP).		
	Truskin Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not		
Q4167		subject to pre-service review. Check EIU policy, which is	-	_
		one of our Clinical Payment and Coding Policy (CPCP).		
	Amnioband 1 Mg	MP Criteria: Procedure/service reviewed against Medical		
Q4168		Policy Criteria. Submit for Recommended Clinical Review to	_	-
		avoid post-service review.		
	Artacent Wound Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not		
Q4169		subject to pre-service review. Check EIU policy, which is	_	_
		one of our Clinical Payment and Coding Policy (CPCP).		
	Cygnus Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not		
Q4170		subject to pre-service review. Check EIU policy, which is	_	_
		one of our Clinical Payment and Coding Policy (CPCP).		
	Interfyl 1 Mg	EIU: Procedure/service not reimbursed by the Plan. Not		
Q4171		subject to pre-service review. Check EIU policy, which is	_	_
		one of our Clinical Payment and Coding Policy (CPCP).		
	Palingen Or Palingen Xplus Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not		
Q4173		subject to pre-service review. Check EIU policy, which is	_	_
		one of our Clinical Payment and Coding Policy (CPCP).		
	Palingen Or Promatrx 0.36 Mg Per 0.25 Cc	EIU: Procedure/service not reimbursed by the Plan. Not		
Q4174		subject to pre-service review. Check EIU policy, which is	_	_
		one of our Clinical Payment and Coding Policy (CPCP).		

	len e e e e			
	Miroderm Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not		
Q4175		subject to pre-service review. Check EIU policy, which is	_	_
		one of our Clinical Payment and Coding Policy (CPCP).		
	Neopatch Or Therion Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not		
Q4176		subject to pre-service review. Check EIU policy, which is	_	_
		one of our Clinical Payment and Coding Policy (CPCP).		
	Floweramnioflo 0.1 Cc	EIU: Procedure/service not reimbursed by the Plan. Not		
Q4177		subject to pre-service review. Check EIU policy, which is	_	_
		one of our Clinical Payment and Coding Policy (CPCP).		
	Floweramniopatch Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not		
Q4178		subject to pre-service review. Check EIU policy, which is	_	_
		one of our Clinical Payment and Coding Policy (CPCP).		
	Flowerderm Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not		
Q4179		subject to pre-service review. Check EIU policy, which is	L	_
		one of our Clinical Payment and Coding Policy (CPCP).		
	Revita Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not		
Q4180		subject to pre-service review. Check EIU policy, which is	_	_
		one of our Clinical Payment and Coding Policy (CPCP).		
	Amnio Wound Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not		
Q4181		subject to pre-service review. Check EIU policy, which is		
		one of our Clinical Payment and Coding Policy (CPCP).	<u> </u>	_
	Transcyte Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not		
Q4182		subject to pre-service review. Check EIU policy, which is		
		one of our Clinical Payment and Coding Policy (CPCP).	<u> </u>	_
	Surgigraft Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not		
Q4183		subject to pre-service review. Check EIU policy, which is		
		one of our Clinical Payment and Coding Policy (CPCP).	<u> </u>	_
	Cellesta Or Cellesta Duo Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not		
Q4184	concesta or concesta data i en oquane continueten	subject to pre-service review. Check EIU policy, which is		
		one of our Clinical Payment and Coding Policy (CPCP).	-	_
	Cellesta Flowable Amnion (25 Mg Per Cc); Per 0.5 Cc	EIU: Procedure/service not reimbursed by the Plan. Not		
Q4185	cellesta Flowable / Illimon (25 Mg Fel ee), Fel ols ee	subject to pre-service review. Check EIU policy, which is		
Q 1203		one of our Clinical Payment and Coding Policy (CPCP).	-	_
	Epifix Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical		
Q4186	Epinix i er square certameter	Policy Criteria. Submit for Recommended Clinical Review to _		
Q 1200		avoid post-service review.	<u> </u> -	-
	Epicord Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical		
Q4187	Epicora i el square certameter	Policy Criteria. Submit for Recommended Clinical Review to		
Q4107		avoid post-service review.	-	-
	Amnioarmor Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not		
Q4188	Annioannoi Fei Square Centimetei	subject to pre-service review. Check EIU policy, which is		
Q4100			-	-
	Artacont Ac. 1 Mg	one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not		
04190	Artacent Ac 1 Mg			
Q4189		subject to pre-service review. Check EIU policy, which is	-	-
	Arte cont An Don Course Continue to	one of our Clinical Payment and Coding Policy (CPCP).		
04100	Artacent Ac Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not		
Q4190		subject to pre-service review. Check EIU policy, which is	-	-
		one of our Clinical Payment and Coding Policy (CPCP).		

	Restorigin Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4191	Restorigin Per Square Centimeter				
Q4191		subject to pre-service review. Check EIU policy, which is	-	-	-
	Postoriais 1 Co	one of our Clinical Payment and Coding Policy (CPCP).			
0.4103	Restorigin 1 Cc	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4192		subject to pre-service review. Check EIU policy, which is	-	-	-
		one of our Clinical Payment and Coding Policy (CPCP).			
	Coll-E-Derm Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4193		subject to pre-service review. Check EIU policy, which is	-	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Novachor Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4194		subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Puraply Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4195		subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Puraply Am Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4196		subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Puraply Xt Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4197		subject to pre-service review. Check EIU policy, which is	_		_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Genesis Amniotic Membrane Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4198	· ·	subject to pre-service review. Check EIU policy, which is			
		one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
	Cygnus Matrix Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4199	,,,	subject to pre-service review. Check EIU policy, which is			
		one of our Clinical Payment and Coding Policy (CPCP).	=	_	_
	Skin Te Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4200		subject to pre-service review. Check EIU policy, which is			
		one of our Clinical Payment and Coding Policy (CPCP).	_	_	-
	Matrion Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4201	Watton Tel square centimeter	subject to pre-service review. Check EIU policy, which is			
Q 1201		one of our Clinical Payment and Coding Policy (CPCP).	-	_	-
	Keroxx (2.5G/Cc) 1Cc	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4202	(2.3d/CC) 1CC	subject to pre-service review. Check EIU policy, which is			
Q4202		one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
	Derma-Gide Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4203	Derma-Gide Fei Square Centimeter	subject to pre-service review. Check EIU policy, which is			
Q4203			-	-	-
	Vuyan Dar Cauara Contimator	one of our Clinical Payment and Coding Policy (CPCP).			
04304	Xwrap Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4204		subject to pre-service review. Check EIU policy, which is	-	-	-
	Marchana Carli Ochra III III Carl	one of our Clinical Payment and Coding Policy (CPCP).			
	Membrane Graft Or Membrane Wrap Per Square	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4205	Centimeter	subject to pre-service review. Check EIU policy, which is	-	-	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Fluid Flow Or Fluid Gf 1 Cc	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4206		subject to pre-service review. Check EIU policy, which is	-	-	_
		one of our Clinical Payment and Coding Policy (CPCP).			

	Novafix Per Square Cenitmeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4208	Novanx Tel Square cemanical	subject to pre-service review. Check EIU policy, which is			
Q4200		one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
	Surgraft Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4209	Surgialt Fel Square Cellumeter	subject to pre-service review. Check EIU policy, which is			
Q4203		one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
	Axolotl Graft Or Axolotl Dualgraft Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4210	Axoloti Graft Of Axoloti bualgraft. Fer Square Certifficer	subject to pre-service review. Check EIU policy, which is			
Q4210		one of our Clinical Payment and Coding Policy (CPCP).	_	-	-
	Amnian Dia Or Avahiamamhrana Dar Cauara Contimator	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4211	Amnion Bio Or Axobiomembrane Per Square Centimeter	subject to pre-service review. Check EIU policy, which is			
Q4211			_	-	-
	Alleger Ber Ce	one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not			
04242	Allogen Per Cc	· ·			
Q4212		subject to pre-service review. Check EIU policy, which is	-	-	-
	A	one of our Clinical Payment and Coding Policy (CPCP).			
0.4242	Ascent 0.5 Mg	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4213		subject to pre-service review. Check EIU policy, which is	_	-	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Cellesta Cord Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4214		subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Axolotl Ambient Or Axolotl Cryo 0.1 Mg	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4215		subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Artacent Cord Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4216		subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Woundfix Biowound Woundfix Plus Biowound Plus	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4217	Woundfix Xplus Or Biowound Xplus Per Square Centimeter	subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Surgicord Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4218		subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Surgigraft-Dual Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4219		subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Bellacell Hd Or Surederm Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4220		subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Amniowrap2 Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4221		subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Progenamatrix Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4222		subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Human Health Factor 10 Amniotic Patch (Hhf10-P) Per	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4224	Square Centimeter	subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			

	Amniobind Or Dermabind Tl Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4225	Anniobilia of Dermabilia II Fel Square Centimeter	subject to pre-service review. Check EIU policy, which is			
Q4223		one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
	Amniocore Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4227	Anniocore rei square centimeter	subject to pre-service review. Check EIU policy, which is			
Q4227		one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
	Caganay Amniatia Mambrana Day Sayara Continutor	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4229	Cogenex Amniotic Membrane Per Square Centimeter	subject to pre-service review. Check EIU policy, which is			
Q4229			_	_	-
	Construction and a property of the contract of	one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not			
04220	Cogenex Flowable Amnion Per 0.5 Cc				
Q4230		subject to pre-service review. Check EIU policy, which is	-	-	-
		one of our Clinical Payment and Coding Policy (CPCP).			
0.400.4	Corplex P Per Cc	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4231		subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Corplex Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4232		subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Surfactor Or Nudyn Per 0.5 Cc	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4233		subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Xcellerate Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4234		subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Amniorepair Or Altiply Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4235		subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Carepatch Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4236		subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Cryo-Cord Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4237		subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Derm-Maxx Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4238		subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Amnio-Maxx Or Amnio-Maxx Lite Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4239		subject to pre-service review. Check EIU policy, which is			
		one of our Clinical Payment and Coding Policy (CPCP).			
	Corecyte For Topical Use Only Per 0.5 Cc	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4240	,	subject to pre-service review. Check EIU policy, which is			
		one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
	Polycyte For Topical Use Only Per 0.5 Cc	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4241	2.,2,12 . 2 2,12. 223 3, . 3. 3.3 33	subject to pre-service review. Check EIU policy, which is			
		one of our Clinical Payment and Coding Policy (CPCP).	_	_	-
	Amniocyte Plus Per 0.5 Cc	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4242	Allillocyte Flus Tel 0.5 cc	subject to pre-service review. Check EIU policy, which is			
Q-12-72			-	-	-
		one of our Clinical Payment and Coding Policy (CPCP).			

	Procenta, per 200 mg	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4244		subject to pre-service review. Check EIU policy, which is			
		one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020		
	Amniotext Per Cc	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4245		subject to pre-service review. Check EIU policy, which is			
		one of our Clinical Payment and Coding Policy (CPCP).		_	_
	Coretext Or Protext Per Cc	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4246		subject to pre-service review. Check EIU policy, which is			
·		one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
	Amniotext Patch Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4247		subject to pre-service review. Check EIU policy, which is			
		one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
	Dermacyte Amniotic Membrane Allograft Per Square	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4248	Centimeter	subject to pre-service review. Check EIU policy, which is			
	Gentimiete.	one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
	Amniply For Topical Use Only Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4249	p, 1 sp. 1 sq. 1 sq. 1	subject to pre-service review. Check EIU policy, which is			
		one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
	Amnioamp-Mp Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4250	annount mp recoquate continuete.	subject to pre-service review. Check EIU policy, which is			
α.230		one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
	Vim Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4251	viii rei square certaineter	subject to pre-service review. Check EIU policy, which is			
Q1231		one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
	Vendaje Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4252	vendaje i el square centimeter	subject to pre-service review. Check EIU policy, which is			
ζ.252		one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
	Zenith Amniotic Membrane Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4253	Zentar / annotic Wembrane 1 er square centameter	subject to pre-service review. Check EIU policy, which is			
ζ.255		one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
	Novafix DI Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4254	norally by the square continuete.	subject to pre-service review. Check EIU policy, which is			
ζ.23 .		one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
	Reguard For Topical Use Only Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4255	negativa i or represendate demande demandeter	subject to pre-service review. Check EIU policy, which is			
ζ.255		one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
	Mlg-Complete Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4256	img complete rel square centimeter	subject to pre-service review. Check EIU policy, which is			
Q1230		one of our Clinical Payment and Coding Policy (CPCP).	_	-	-
	Relese Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4257	nelese i el square centimeter	subject to pre-service review. Check EIU policy, which is			
Q1237		one of our Clinical Payment and Coding Policy (CPCP).	-	-	_
	Enverse Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4258	Liverse i ei square centimeter	subject to pre-service review. Check EIU policy, which is			
Q4230		one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
	Celera Dual Layer Or Celera Dual Membrane Per Square	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4259	· · · · · · · · · · · · · · · · · · ·	subject to pre-service review. Check EIU policy, which is			
Q42J3	Centimeter		-	-	-
		one of our Clinical Payment and Coding Policy (CPCP).			

	Signature Apatch Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4260		subject to pre-service review. Check EIU policy, which is			
		one of our Clinical Payment and Coding Policy (CPCP).	_	<u> </u>	_
	Tag Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4261		subject to pre-service review. Check EIU policy, which is			
		one of our Clinical Payment and Coding Policy (CPCP).	-	_	-
	Dual Layer Impax Membrane Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4262	but Layer impax Wembrane Ter square centimeter	subject to pre-service review. Check EIU policy, which is			
Q 1202		one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
	Surgraft TI Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4263	Suigrant II Tel Square centimeter	subject to pre-service review. Check EIU policy, which is			
Q4203		one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
	Cocoon Membrane Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4264	Cocoon Membrane Fer Square Centimeter	subject to pre-service review. Check EIU policy, which is			
Q4204			-	-	-
	Neasting TI Day Causes Continuator	one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not			
04265	Neostim TI Per Square Centimeter	· ·			
Q4265		subject to pre-service review. Check EIU policy, which is	-	-	-
		one of our Clinical Payment and Coding Policy (CPCP).			
	Neostim Membrane Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4266		subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Neostim DI Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4267		subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Surgraft Ft Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4268		subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Surgraft Xt Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4269		subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Complete SI Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4270		subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Complete Ft Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4271		subject to pre-service review. Check EIU policy, which is			_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Esano A Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4272		subject to pre-service review. Check EIU policy, which is			
		one of our Clinical Payment and Coding Policy (CPCP).		Ī	_
	Esano Aaa Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4273		subject to pre-service review. Check EIU policy, which is			
ζ.273		one of our Clinical Payment and Coding Policy (CPCP).	-	_	-
	Esano Ac Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4274	Estato Ac Tel Square centimeter	subject to pre-service review. Check EIU policy, which is			
Q42/4		one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
	Econo Aco Par Sauara Continator	EIU: Procedure/service not reimbursed by the Plan. Not			
04275	Esano Aca Per Square Centimeter				
Q4275		subject to pre-service review. Check EIU policy, which is	-	-	-
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Trimabind DI Per Square Centimeter MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). Trimabind DI Per Square Centimeter EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). Trimabind Ch Per Square Centimeter MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). Trimabind Ch Per Square Centimeter	subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (PCPP). Warned Tri-Layer Or Biovance 3L. Per Square Centimeter Whe Criteria: Submit for Recommended Clinical Review to avoid post-service review. Fig. 12. Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (PCPP). Blu: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (PCP). Blu: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (PCP). Blu: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (PCP). Blu: Procedure/service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (PCP). Blu: Procedure/service review dagainst Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Blu: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (PCP). Blu: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (PCP). Blu: Procedure/service review dagainst Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (PCP). Blu: Procedure/service review dagainst Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (PCP). Blu: Procedure/service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (PCP).

	Revoshield + Amniotic Barrier Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical			A L L CC .: 00/45/0004
Q4289		Policy Criteria. Submit for Recommended Clinical Review to		2 /22 /222	Add effective 03/15/2024
		avoid post-service review.	3/15/2024	6/30/2024	Retire effecitve 06/30/2024
	Revoshield + Amniotic Barrier Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4289		subject to pre-service review. Check EIU policy, which is		_	
		one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024		Add effective 07/01/2024
	Membrane Wrap-Hydro Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical			
Q4290		Policy Criteria. Submit for Recommended Clinical Review to			Add effective 03/15/2024
		avoid post-service review.	3/15/2024	6/30/2024	Retire effecitve 06/30/2024
	Membrane Wrap-Hydro Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4290		subject to pre-service review. Check EIU policy, which is		_	
		one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024		Add effective 07/01/2024
	Lamellas Xt Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical			
Q4291		Policy Criteria. Submit for Recommended Clinical Review to			Add effective 03/15/2024
		avoid post-service review.	3/15/2024	6/30/2024	Retire effecitve 06/30/2024
	Lamellas Xt Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4291		subject to pre-service review. Check EIU policy, which is		_	
		one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024		Add effective 07/01/2024
	Lamellas Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical			
Q4292		Policy Criteria. Submit for Recommended Clinical Review to			Add effective 03/15/2024
		avoid post-service review.	3/15/2024	6/30/2024	Retire effecitve 06/30/2024
	Lamellas Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4292		subject to pre-service review. Check EIU policy, which is		_	
		one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024		Add effective 07/01/2024
	Acesso DI Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical			
Q4293		Policy Criteria. Submit for Recommended Clinical Review to			Add effective 03/15/2024
		avoid post-service review.	3/15/2024	6/30/2024	Retire effecitve 06/30/2024
	Acesso DI Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4293		subject to pre-service review. Check EIU policy, which is		_	
		one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024		Add effective 07/01/2024
	Amnio Quad-Core Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical			
Q4294		Policy Criteria. Submit for Recommended Clinical Review to			Add effective 03/15/2024
		avoid post-service review.	3/15/2024	6/30/2024	Retire effecitve 06/30/2024
	Amnio Quad-Core Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4294		subject to pre-service review. Check EIU policy, which is			
		one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024		Add effective 07/01/2024
	Amnio Tri-Core Amniotic Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical			
Q4295		Policy Criteria. Submit for Recommended Clinical Review to			Add effective 03/15/2024
		avoid post-service review.	3/15/2024	6/30/2024	Retire effecitve 06/30/2024
	Amnio Tri-Core Amniotic Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4295		subject to pre-service review. Check EIU policy, which is			
		one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	_	Add effective 07/01/2024
	Rebound Matrix Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical			. , . ,
Q4296		Policy Criteria. Submit for Recommended Clinical Review to			Add effective 03/15/2024
		avoid post-service review.	3/15/2024	6/30/2024	Retire effecitive 06/30/2024
	Rebound Matrix Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not	-, 20, 202 1	0, 30, 2024	2 2 2222 00/00/2021
Q4296	nesound Muthix Tel Square Cellumeter	subject to pre-service review. Check EIU policy, which is			
Q.230			7/1/2024	_	Add effective 07/01/2024
		one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024		Add effective 07/01/2024

	Emerge Matrix Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical			A L L CC .: 00/45/0004
Q4297		Policy Criteria. Submit for Recommended Clinical Review to		c /20 /200	Add effective 03/15/2024
		avoid post-service review.	3/15/2024	6/30/2024	Retire effecitve 06/30/2024
	Emerge Matrix Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4297		subject to pre-service review. Check EIU policy, which is	_ 4. 4	_	
		one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024		Add effective 07/01/2024
	Amnicore Pro Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical			
Q4298		Policy Criteria. Submit for Recommended Clinical Review to		. / /	Add effective 03/15/2024
		avoid post-service review.	3/15/2024	6/30/2024	Retire effecitve 06/30/2024
	Amnicore Pro Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4298		subject to pre-service review. Check EIU policy, which is		_	
		one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024		Add effective 07/01/2024
	Amnicore Pro+ Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical			
Q4299		Policy Criteria. Submit for Recommended Clinical Review to			Add effective 03/15/2024
		avoid post-service review.	3/15/2024	6/30/2024	Retire effecitve 06/30/2024
	Amnicore Pro+ Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4299		subject to pre-service review. Check EIU policy, which is		_	
		one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024		Add effective 07/01/2024
	Acesso TI Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical			
Q4300		Policy Criteria. Submit for Recommended Clinical Review to			Add effective 03/15/2024
		avoid post-service review.	3/15/2024	6/30/2024	Retire effecitve 06/30/2024
	Acesso TI Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4300		subject to pre-service review. Check EIU policy, which is		_	
		one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024		Add effective 07/01/2024
	Activate Matrix Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical			
Q4301		Policy Criteria. Submit for Recommended Clinical Review to			Add effective 03/15/2024
		avoid post-service review.	3/15/2024	6/30/2024	Retire effecitve 06/30/2024
	Activate Matrix Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4301		subject to pre-service review. Check EIU policy, which is		_	
		one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024		Add effective 07/01/2024
	Complete Aca Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical			
Q4302		Policy Criteria. Submit for Recommended Clinical Review to			Add effective 03/15/2024
		avoid post-service review.	3/15/2024	6/30/2024	Retire effecitve 06/30/2024
	Complete Aca Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4302		subject to pre-service review. Check EIU policy, which is			
		one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024		Add effective 07/01/2024
	Complete Aa Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical			
Q4303	· ·	Policy Criteria. Submit for Recommended Clinical Review to			Add effective 03/15/2024
		avoid post-service review.	3/15/2024	6/30/2024	Retire effecitve 06/30/2024
	Complete Aa Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not			
Q4303		subject to pre-service review. Check EIU policy, which is			
		one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	_	Add effective 07/01/2024
	Grafix Plus Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical			
Q4304	Statistic Constitution	Policy Criteria. Submit for Recommended Clinical Review to			
∡ 100 7		i one, criteria. Submit for recommended clinical neview to		 - -	

	Annanian Annaian As Tri Lauran Ban Causan	FILL Decoding forming ast univelyment by the Dien		
	American Amnion Ac Tri-Layer Per Square	EIU: Procedure/service not reimbursed by the Plan.		
Q4305	Centimeter	Not subject to pre-service review. Check EIU policy,		
4.555		which is one of our Clinical Payment and Coding		-
		Policy (CPCP).	4/1/2024	Add effective 04/01/202
	American Amnion Ac Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan.		
0.4200		Not subject to pre-service review. Check EIU policy,		
Q4306		which is one of our Clinical Payment and Coding		-
		Policy (CPCP).	4/1/2024	Add effective 04/01/202
	American Amnion Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan.		
		Not subject to pre-service review. Check EIU policy,		
Q4307		which is one of our Clinical Payment and Coding		_
		Policy (CPCP).	4/1/2024	Add effective 04/01/202
	Sanopellis Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan.	7/ 1/2024	7 tud effective 0-4/01/202
	Sanopenis Per Square Centimeter	Not subject to pre-service review. Check EIU policy,		
Q4308		The state of the s		
		which is one of our Clinical Payment and Coding	. /. /2.22	4 1 1 55 11 04/04/202
		Policy (CPCP).	4/1/2024	Add effective 04/01/202
	Via Matrix Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan.		
Q4309		Not subject to pre-service review. Check EIU policy,		
Q 1303		which is one of our Clinical Payment and Coding		-
		Policy (CPCP).	4/1/2024	Add effective 04/01/202
	Procenta Per 100 Mg	EIU: Procedure/service not reimbursed by the Plan.		
Q4310		Not subject to pre-service review. Check EIU policy,		
Q4310		which is one of our Clinical Payment and Coding		-
		Policy (CPCP).	4/1/2024	Add effective 04/01/202
Q5009	Hospice Or Home Health Care Provided In Place Not	Unlisted: Procedure/service not specifically defined or		
	Otherwise Specified (Nos)	classified, maybe subject to contract/clinical review.	-	
	Injection Infliximab-Dyyb Biosimilar (Inflectra) 10 Mg	MP Criteria: Procedure/service reviewed against Medical		
Q5103		Policy Criteria. Submit for Recommended Clinical Review to		
		avoid post-service review. Prior Authorization may be	_	
	Injection Infliximab-Abda Biosimilar (Renflexis) 10 Mg	required per contract agreement. MP Criteria: Procedure/service reviewed against Medical		
	injection inniximab-Abda Biosimilar (Rennexis) 10 Mg	Policy Criteria. Submit for Recommended Clinical Review to		
Q5104		avoid post-service review. Prior Authorization may be	_	
		required per contract agreement.		
	Injection Epoetin Alfa-Epbx Biosimilar (Retacrit) (For Non-	MP Criteria: Procedure/service reviewed against Medical		
05406	Esrd Use) 1000 Units	Policy Criteria. Submit for Recommended Clinical Review to		
Q5106		avoid post-service review. Prior Authorization may be	-	-
		required per contract agreement.		
	Injection Infliximab-Qbtx Biosimilar (Ixifi) 10 Mg	MP Criteria: Procedure/service reviewed against Medical		
Q5109		Policy Criteria. Submit for Recommended Clinical Review to		
QJ10J		avoid post-service review. Prior Authorization may be	-	-
		required per contract agreement.		

	Injection Desibirumeh Nune Dissimilar (Dusquir) O.1 Mg	MP Criteria: Procedure/service reviewed against Medical			
05124	Injection Ranibizumab-Nuna Biosimilar (Byooviz) 0.1 Mg	·			
Q5124		Policy Criteria. Submit for Recommended Clinical Review to	-	-	_
	Injustice Desibiouseh Fore (Circuit) Dissipation 0.1 Mg	avoid post-service review.			
05130	Injection Ranibizumab-Eqrn (Cimerli) Biosimilar 0.1 Mg	MP Criteria: Procedure/service reviewed against Medical			
Q5128		Policy Criteria. Submit for Recommended Clinical Review to	-	-	-
	1 1 1 7 11 1 2 1/7 (1 1 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	avoid post-service review.			
	Injection Tocilizumab-Bavi (Tofidence) Biosimilar 1 Mg	MP Criteria: Procedure/service reviewed against			
Q5133		Medical Policy Criteria. Submit for Recommended		_	
		Clinical Review to avoid post-service review.	8/1/2024		
	Injection Natalizumab-Sztn (Tyruko) Biosimilar 1 Mg	MP Criteria: Procedure/service reviewed against			Add effective 07/01/2024
Q5134		Medical Policy Criteria. Submit for Recommended			
		Clinical Review to avoid post-service review.	7/1/2024	_	
	Esketamine Nasal Spray 1 Mg	MP Criteria: Procedure/service reviewed against Medical	-7-7		
S0013	Esketarrine Nasar Spray 1 Mg	Policy Criteria. Submit for Recommended Clinical Review to			
50015		avoid post-service review.	_	_	_
	Tretinoin Topical 5 Grams	Non Covered: Procedure/service not covered by the Plan.			
S0117	Tretinom Topical 3 Grams	Not subject to pre-service review.	_	_	_
	Colistimethate Sodium Inhalation Solution Administered	Non Covered: Procedure/service not covered by the Plan.			
S0142	Through Dme Concentrated Form Per Mg	Not subject to pre-service review.	_	_	_
	Becaplermin Gel 0. 01% 0. 5 Gm	MP Criteria: Procedure/service reviewed against Medical			
	becapieriiiii dei 0. 01% 0. 3 diii	Policy Criteria. Submit for Recommended Clinical Review to			
S0157		-	_	_	_
		avoid post-service review. Prior Authorization may be			
	Proposal Vitamina 20 Day Cumhy	required per contract agreement. Non Covered: Procedure/service not covered by the Plan.			
S0197	Prenatal Vitamins 30-Day Supply	· ·	_	_	_
	Heavitalist Comises / List Computally In Addition To Code Com	Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan.			
S0310	Hospitalist Services (List Separately In Addition To Code For	· ·	_	_	_
	Appropriate Evaluation And Management Service)	Not subject to pre-service review.			
50220	Telephone Calls By A Registered Nurse To A Disease	Non Covered: Procedure/service not covered by the Plan.			
S0320	Management Program Member For Monitoring Purposes;	Not subject to pre-service review.	-	-	-
	Per Month	Halland Board of the Control of Scotlands Control			
S0590	Integral Lens Service Miscellaneous Services Reported	Unlisted: Procedure/service not specifically defined or	_	_	
	Separately 062 for its 5	classified, maybe subject to contract/clinical review.			
50505	Phakic Intraocular Lens For Correction Of Refractive Error	MP Criteria: Procedure/service reviewed against Medical			
S0596		Policy Criteria. Submit for Recommended Clinical Review to		_	A del official of 02/45/2024
	21	avoid post-service review.	2/15/2024		Add effective 02/15/2024
	Physical Exam For College New Or Established Patient (List	Non Covered: Procedure/service not covered by the Plan.			
S0622	Separately In Addition To Appropriate Evaluation And	Not subject to pre-service review.	-	_	_
	Management Code)				
	Laser In Situ Keratomileusis (Lasik)	MP Criteria: Procedure/service reviewed against Medical			
S0800		Policy Criteria. Submit for Recommended Clinical Review to	_	_	-
		avoid post-service review.			
S0810	Photorefractive Keratectomy (Prk)	Non Covered: Procedure/service not covered by the Plan.			
		Not subject to pre-service review.	-	-	-
S1001	Deluxe Item Patient Aware (List In Addition To Code For	Unlisted: Procedure/service not specifically defined or			
22001	Basic Item)	classified, maybe subject to contract/clinical review.	-	-	-
S1002	Customized Item (List In Addition To Code For Basic Item)	Unlisted: Procedure/service not specifically defined or			
5-002		classified, maybe subject to contract/clinical review.	-	-	-

	Stent Non-Coronary Temporary With Delivery System	MP Criteria: Procedure/service reviewed against Medical			
S1091	(Propel)	Policy Criteria. Submit for Recommended Clinical Review to			
31031	(i Topei)	avoid post-service review.	_	-	-
	Transplantation Of Small Intestine And Liver Allografts	MP Criteria: Procedures/services reviewed against Medical			Moved from PA to
S2053	Transplantation of small intestine vina liver vinagiants	Policy Criteria. Submit for Recommended Clinical Review to			Recommended Clinical Review
02000		avoid post-service review by BCBS.	_	-	9/18/2023
	Transplantation Of Multivisceral Organs	MP Criteria: Procedures/services reviewed against Medical			Moved from PA to
S2054	Transplantation of Mattwisectal Organs	Policy Criteria. Submit for Recommended Clinical Review to			Recommended Clinical Review
32031		avoid post-service review by BCBS.	_	-	9/18/2023
	Lobar Lung Transplantation	MP Criteria: Procedures/services reviewed against Medical			Moved from PA to
S2060	Loods Eding Transplantation	Policy Criteria. Submit for Recommended Clinical Review to			Recommended Clinical Review
02000		avoid post-service review by BCBS.	_	-	9/18/2023
	Simultaneous Pancreas Kidney Transplantation	MP Criteria: Procedures/services reviewed against Medical			Moved from PA to
S2065	omataneous randicus mane, manopiamaton	Policy Criteria. Submit for Recommended Clinical Review to			Recommended Clinical Review
02000		avoid post-service review by BCBS.	_	-	9/18/2023
	Adjustment Of Gastric Band Diameter Via Subcutaneous	MP Criteria: Procedure/service reviewed against Medical			3/10/2023
S2083	Port By Injection Or Aspiration Of Saline	Policy Criteria. Submit for Recommended Clinical Review to			
32003	Tore by injection of Aspiration of Sainte	avoid post-service review.	_	-	-
	Arthroscopy Knee Surgical For Harvesting Of Cartilage	MP Criteria: Procedure/service reviewed against Medical			
S2112	(Chondrocyte Cells)	Policy Criteria. Submit for Recommended Clinical Review to			
32112	(Chondrocyte cens)	avoid post-service review.	_	-	-
	Arthroereisis Subtalar	EIU: Procedure/service not reimbursed by the Plan. Not			
S2117	A CHI OCI CISIS SUBCUIUI	subject to pre-service review. Check EIU policy, which is			
52117		one of our Clinical Payment and Coding Policy (CPCP).	_	-	-
	Metal-On-Metal Total Hip Resurfacing Including Acetabular	MP Criteria: Procedure/service reviewed against Medical			
S2118	And Femoral Components	Policy Criteria. Submit for Recommended Clinical Review to			
	And remotal components	avoid post-service review.	_	_	_
	Low Density Lipoprotein (Ldl) Apheresis Using Heparin-	MP Criteria: Procedure/service reviewed against Medical			
	Induced Extracorporeal Ldl Precipitation	Policy Criteria. Submit for Recommended Clinical Review to			
S2120	maded Extracorpored Edit recipitation	avoid post-service review. Prior Authorization may be	_	_	-
		required per contract agreement.			
	Cord Blood Harvesting For Transplantation Allogeneic	MP Criteria: Procedure/service reviewed against Medical			
S2140	ond processing for manapianication / mogentine	Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review.	_	_	_
	Cord Blood-Derived Stem-Cell Transplantation Allogeneic	MP Criteria: Procedure/service reviewed against Medical			
S2142	cord proced permed ocen manophanication / mogenture	Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review.	_	_	_
	Bone Marrow Or Blood-Derived Stem Cells (Peripheral Or				
	Umbilical) Allogeneic Or Autologous Harvesting				
	Transplantation And Related Complications; Including:				
	Pheresis And Cell Preparation/Storage; Marrow Ablative	MP Criteria: Procedure/service reviewed against Medical			
S2150	Therapy; Drugs Supplies Hospitalization With Outpatient	Policy Criteria. Submit for Recommended Clinical Review to	_	-	_
	Follow-Up; Medical/Surgical Diagnostic Emergency And	avoid post-service review.			
	Rehabilitative Services; And The Number Of Days Of Pre-And				
	Post-Transplant Care In The Global Definition				
	170St-114HSDIAIR Care III The Global Definition				

	Calcasal a saabhassassassassassassassassassassassassass	MD Critoria, Dragadura/sarviga reviewed against Madigal			
	Echosclerotherapy	MP Criteria: Procedure/service reviewed against Medical			
S2202		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	_ · · · · · · · · · · · · · · · · · · ·	MP Criteria: Procedure/service reviewed against Medical			
S2230	Hearing Device On Ossicles In Middle Ear	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Implantation Of Auditory Brain Stem Implant	MP Criteria: Procedure/service reviewed against Medical			
S2235		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Arthroscopy Shoulder Surgical; With Thermally-Induced	EIU: Procedure/service not reimbursed by the Plan. Not			
S2300	Capsulorrhaphy	subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Repair Congenital Diaphragmatic Hernia In The Fetus Using	MP Criteria: Procedure/service reviewed against Medical			
S2400	Temporary Tracheal Occlusion Procedure Performed In	Policy Criteria. Submit for Recommended Clinical Review to			
	Utero	avoid post-service review.	_		
	Repair Urinary Tract Obstruction In The Fetus Procedure	MP Criteria: Procedure/service reviewed against Medical			
S2401	Performed In Utero	Policy Criteria. Submit for Recommended Clinical Review to			
	Terrormed in otero	avoid post-service review.	_	_	_
	Repair Congenital Cystic Adenomatoid Malformation In The				
S2402	Fetus Procedure Performed In Utero	Policy Criteria. Submit for Recommended Clinical Review to			
32402	retus riocedure renormed in otero	avoid post-service review.	_	-	_
	Repair Extralobar Pulmonary Sequestration In The Fetus	MP Criteria: Procedure/service reviewed against Medical			
52402		Policy Criteria. Submit for Recommended Clinical Review to			
S2403	Procedure Performed In Utero	· ·	_	-	_
	Dancin Muslamania sasala la The Fetus Dancedous	avoid post-service review. MP Criteria: Procedure/service reviewed against Medical			
62404	Repair Myelomeningocele In The Fetus Procedure	_			
S2404	Performed In Utero	Policy Criteria. Submit for Recommended Clinical Review to	_	-	
		avoid post-service review.			
	Repair Of Sacrococcygeal Teratoma In The Fetus Procedure	MP Criteria: Procedure/service reviewed against Medical			
S2405	Performed In Utero	Policy Criteria. Submit for Recommended Clinical Review to	_	-	_
		avoid post-service review.			
S2409	Repair Congenital Malformation Of Fetus Procedure	Unlisted: Procedure/service not specifically defined or			
32 103	Performed In Utero Not Otherwise Classified	classified, maybe subject to contract/clinical review.	_	-	_
	Repair Congenital Malformation Of Fetus Procedure	MP Criteria: Procedure/service reviewed against Medical			
S2409	Performed In Utero Not Otherwise Classified	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Fetoscopic Laser Therapy For Treatment Of Twin-To-Twin	MP Criteria: Procedure/service reviewed against Medical			
S2411	Transfusion Syndrome	Policy Criteria. Submit for Recommended Clinical Review to	_		
		avoid post-service review.			
	Surgical Techniques Requiring Use Of Robotic Surgical	MP Criteria: Procedure/service reviewed against Medical			
S2900	System (List Separately In Addition To Code For Primary	Policy Criteria. Submit for Recommended Clinical Review to			
	Procedure)	avoid post-service review.	_	<u></u>	-
	Stat Laboratory Request (Situations Other Than S3601)	Non Covered: Procedure/service not covered by the Plan.			
S3600	State Education y recognistic (State of State of	Not subject to pre-service review.	_	_	_
	Emergency Stat Laboratory Charge For Patient Who Is	Non Covered: Procedure/service not covered by the Plan.			
S3601			_	_	_
	Homebound Or Residing In A Nursing Facility	Not subject to pre-service review.			

	Saliva Test Hormone Level; During Menopause	EIU: Procedure/service not reimbursed by the Plan. Not			
S3650		subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Saliva Test Hormone Level; To Assess Preterm Labor Risk	EIU: Procedure/service not reimbursed by the Plan. Not			
S3652		subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
	Genetic Testing For Amyotrophic Lateral Sclerosis (Als)	MP Criteria: Procedures/services reviewed against Medical			
S3800		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by Carelon.			
	Dna Analysis For Germline Mutations Of The Ret Proto-	MP Criteria: Procedures/services reviewed against Medical			
S3840	Oncogene For Susceptibility To Multiple Endocrine Neoplasia	Policy Criteria. Submit for Recommended Clinical Review to			
	Type 2	avoid post-service review by Carelon.			
	Genetic Testing For Retinoblastoma	MP Criteria: Procedures/services reviewed against Medical			
S3841		Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review by Carelon.	_	<u>-</u>	_
	Genetic Testing For Von Hippel-Lindau Disease	MP Criteria: Procedures/services reviewed against Medical			
S3842	, , , , , , , , , , , , , , , , , , ,	Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review by Carelon.	_	_	-
	Dna Analysis Of The Connexin 26 Gene (Gjb2) For	MP Criteria: Procedures/services reviewed against Medical			
S3844	Susceptibility To Congenital Profound Deafness	Policy Criteria. Submit for Recommended Clinical Review to			
	Subsceptibility to configuration from the Dearness	avoid post-service review by Carelon.	_	_	-
	Genetic Testing For Alpha-Thalassemia	MP Criteria: Procedures/services reviewed against Medical			
S3845	deficate restaing For Alpha Thalasserina	Policy Criteria. Submit for Recommended Clinical Review to			
330 13		avoid post-service review by Carelon.	_	-	-
	Genetic Testing For Hemoglobin E Beta-Thalassemia	MP Criteria: Procedures/services reviewed against Medical			+
S3846	Genetic resting for Hemoglobin L beta-maiassemia	Policy Criteria. Submit for Recommended Clinical Review to			
33040		avoid post-service review by Carelon.	-	-	-
	Genetic Testing For Niemann-Pick Disease	MP Criteria: Procedures/services reviewed against Medical			+
S3849	Genetic resting for Memanifi-Fick Disease	Policy Criteria. Submit for Recommended Clinical Review to			
33649		· · ·	-	-	-
	Canadia Tastina Fan Sielde Call Anamia	avoid post-service review by Carelon. MP Criteria: Procedures/services reviewed against Medical			+
C20F0	Genetic Testing For Sickle Cell Anemia	·			
S3850		Policy Criteria. Submit for Recommended Clinical Review to	-	-	-
	Dec Analysis For Anna Fasiling A Allala For Consentibility To	avoid post-service review by Carelon.			
62052	Dna Analysis For Apoe Epsilon 4 Allele For Susceptibility To	MP Criteria: Procedures/services reviewed against Medical			
S3852	Alzheimer'S Disease	Policy Criteria. Submit for Recommended Clinical Review to	-	_	-
		avoid post-service review by Carelon.			+
	Genetic Testing For Myotonic Muscular Dystrophy	MP Criteria: Procedures/services reviewed against Medical			
S3853		Policy Criteria. Submit for Recommended Clinical Review to	-	_	_
		avoid post-service review by Carelon.			
	Gene Expression Profiling Panel For Use In The Management				
S3854	Of Breast Cancer Treatment	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by Carelon.			
	Genetic Testing Sodium Channel Voltage-Gated Type V	MP Criteria: Procedures/services reviewed against Medical			
S3861	Alpha Subunit (Scn5A) And Variants For Suspected Brugada	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	Syndrome	avoid post-service review by Carelon.			
	Comprehensive Gene Sequence Analysis For Hypertrophic	MP Criteria: Procedures/services reviewed against Medical			
S3865	Cardiomyopathy	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review by Carelon.			

		MD 0 11 1 D 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			
	Genetic Analysis For A Specific Gene Mutation For	MP Criteria: Procedures/services reviewed against Medical			
S3866	Hypertrophic Cardiomyopathy (Hcm) In An Individual With A		_	-	-
	Known Hcm Mutation In The Family	avoid post-service review by Carelon.			
	Comparative Genomic Hybridization (Cgh) Microarray	MP Criteria: Procedures/services reviewed against Medical			
S3870	Testing For Developmental Delay Autism Spectrum Disorder	Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
	And/Or Intellectual Disability	avoid post-service review by Carelon.			
	Surface Electromyography (Emg)	EIU: Procedure/service not reimbursed by the Plan. Not			
S3900		subject to pre-service review. Check EIU policy, which is	_	_	_
		one of our Clinical Payment and Coding Policy (CPCP).			
S4015	Complete In Vitro Fertilization Cycle Not Otherwise	Unlisted: Procedure/service not specifically defined or			
34015	Specified Case Rate	classified, maybe subject to contract/clinical review.	-	-	_
	Donor Egg Cycle Incomplete Case Rate	MP Criteria: Procedure/service reviewed against Medical			
S4023		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Donor Services For In Vitro Fertilization (Sperm Or Embryo)	MP Criteria: Procedure/service reviewed against Medical			
S4025	Case Rate	Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review.			
	Procurement Of Donor Sperm From Sperm Bank	MP Criteria: Procedure/service reviewed against Medical			
S4026		Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review.	_	_	_
	Storage Of Previously Frozen Embryos	MP Criteria: Procedure/service reviewed against Medical			
S4027	Storage Grive Housey House you	Policy Criteria. Submit for Recommended Clinical Review to			
0.027		avoid post-service review.	_	_	-
	Sperm Procurement And Cryopreservation Services; Initial	MP Criteria: Procedure/service reviewed against Medical			
S4030	Visit	Policy Criteria. Submit for Recommended Clinical Review to			
54030	Visit	avoid post-service review.	-	-	-
	Sperm Procurement And Cryopreservation Services;	MP Criteria: Procedure/service reviewed against Medical			
S4031	Subsequent Visit	Policy Criteria. Submit for Recommended Clinical Review to			
34031	Subsequent visit	avoid post-service review.	-	-	-
	Monitoring And Storage Of Cryopreserved Embryos Per 30	MP Criteria: Procedure/service reviewed against Medical			
S4040		Policy Criteria. Submit for Recommended Clinical Review to			
34040	Days	•	-	_	-
	Ninetine Detained Leaved	avoid post-service review.			
S4990	Nicotine Patches Legend	Non Covered: Procedure/service not covered by the Plan.			_
		Not subject to pre-service review.			
S4991	Nicotine Patches Non-Legend	Non Covered: Procedure/service not covered by the Plan.			
		Not subject to pre-service review.	_	-	_
S4995	Smoking Cessation Gum	Non Covered: Procedure/service not covered by the Plan.			
		Not subject to pre-service review.	_	_	_
S5035	Home Infusion Therapy Routine Service Of Infusion Device	Non Covered: Procedure/service not covered by the Plan.			
	(E. G. Pump Maintenance)	Not subject to pre-service review.	-	-	_
S5036	Home Infusion Therapy Repair Of Infusion Device (E. G.	Non Covered: Procedure/service not covered by the Plan.			
33030	Pump Repair)	Not subject to pre-service review.	-	-	_
S5100	Day Care Services Adult; Per 15 Minutes	Non Covered: Procedure/service not covered by the Plan.			
33100		Not subject to pre-service review.	-	-	-
S5101	Day Care Services Adult; Per Half Day	Non Covered: Procedure/service not covered by the Plan.			
22101		Not subject to pre-service review.	-	-	-

	Day Care Services Adult; Per Diem	Non Covered: Procedure/service not covered by the Plan.			
S5102	Day Care Services Adult, Fel Dielli	Not subject to pre-service review.	_	_	_
	Day Care Services Center-Based; Services Not Included In	Non Covered: Procedure/service not covered by the Plan.			
S5105	Program Fee Per Diem	Not subject to pre-service review.	_	_	_
	Home Care Training To Home Care Client Per 15 Minutes	Non Covered: Procedure/service not covered by the Plan.			
S5108		Not subject to pre-service review.	_	_	_
	Home Care Training To Home Care Client Per Session	Non Covered: Procedure/service not covered by the Plan.			
S5109	ŭ .	Not subject to pre-service review.	-	-	_
05110	Home Care Training Family; Per 15 Minutes	Non Covered: Procedure/service not covered by the Plan.			
S5110		Not subject to pre-service review.	-	-	-
CE111	Home Care Training Family; Per Session	Non Covered: Procedure/service not covered by the Plan.			
S5111		Not subject to pre-service review.	-	-	-
S5115	Home Care Training Non-Family; Per 15 Minutes	Non Covered: Procedure/service not covered by the Plan.			
33113		Not subject to pre-service review.	-	-	-
S5116	Home Care Training Non-Family; Per Session	Non Covered: Procedure/service not covered by the Plan.			
33110		Not subject to pre-service review.	-	-	-
S5120	Chore Services; Per 15 Minutes	Non Covered: Procedure/service not covered by the Plan.			
33120		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 Services; Per 15 Minutes	Non Covered: Procedure/service not covered by the Plan.			
		Not subject to pre-service review.	_	_	_
S5126	Attendant Care Services; Per Diem	Non Covered: Procedure/service not covered by the Plan.			
	U 1 6 i N 2 45 M	Not subject to pre-service review.	_	_	_
	Homemaker Service Nos; Per 15 Minutes	Non Covered: Procedure/service not covered by the Plan.			
CE120		Not subject to pre-service review.			
S5130		Unlisted or Undefined: Procedures/services not specifically	-	-	-
		defined or classified, maybe subject to contract/clinical			
	Homemaker Service Nos; Per Diem	review. Non Covered: Procedure/service not covered by the Plan.			
	Homemaker Service 1403, Fer Diem	Not subject to pre-service review.			
S5131		Unlisted or Undefined: Procedures/services not specifically			
33131		defined or classified, maybe subject to contract/clinical	-	-	-
		review.			
	Companion Care Adult (E. G. Iadl/Adl); Per 15 Minutes	Non Covered: Procedure/service not covered by the Plan.			
S5135	(= 0.000),	Not subject to pre-service review.	_	-	_
	Companion Care Adult (E. G. Iadl/Adl); Per Diem	Non Covered: Procedure/service not covered by the Plan.			
S5136	, , , , , , , , , , , , , , , , , , , ,	Not subject to pre-service review.	-	-	_
CE4.40	Foster Care Adult; Per Diem	Non Covered: Procedure/service not covered by the Plan.			
S5140		Not subject to pre-service review.	-	-	-
CF1.41	Foster Care Adult; Per Month	Non Covered: Procedure/service not covered by the Plan.			
S5141		Not subject to pre-service review.	-	-	-
S5145	Foster Care Therapeutic Child; Per Diem	Non Covered: Procedure/service not covered by the Plan.			
33143		Not subject to pre-service review.	-	-	-
S5146	Foster Care Therapeutic Child; Per Month	Non Covered: Procedure/service not covered by the Plan.			
33140		Not subject to pre-service review.	-	-	-

	Unskilled Posnite Care Not Hespises Per 15 Minutes	Non Covered: Procedure/service not covered by the Plan.			
S5150	Unskilled Respite Care Not Hospice; Per 15 Minutes	Not subject to pre-service review.	_	_	_
	Unskilled Respite Care Not Hospice; Per Diem	Non Covered: Procedure/service not covered by the Plan.			
S5151	oriskined Respite Care Not Hospice, Fer Diem	Not subject to pre-service review.	_	_	_
	Emergency Response System; Installation And Testing	Non Covered: Procedure/service not covered by the Plan.			
S5160	Emergency response system, instandation And resting	Not subject to pre-service review.	_	_	_
	Emergency Response System; Service Fee Per Month	Non Covered: Procedure/service not covered by the Plan.			
S5161	(Excludes Installation And Testing)	Not subject to pre-service review.	_	_	_
	Emergency Response System; Purchase Only	Non Covered: Procedure/service not covered by the Plan.			
S5162	Emergency response system, runandse omy	Not subject to pre-service review.	_	_	_
	Home Modifications; Per Service	Non Covered: Procedure/service not covered by the Plan.			
S5165	Trome Woulders, Fer Service	Not subject to pre-service review.	_	_	_
	Home Delivered Meals Including Preparation; Per Meal	Non Covered: Procedure/service not covered by the Plan.			
S5170	Trome between theats including treparation, tel mean	Not subject to pre-service review.	_	_	_
	Laundry Service External Professional; Per Order	Non Covered: Procedure/service not covered by the Plan.			
S5175	Edulary Service External Professional, Fer Order	Not subject to pre-service review.	_	_	_
	Home Health Respiratory Therapy Nos Per Diem	Unlisted: Procedure/service not specifically defined or			
S5181	The median respiratory merapy was her blem	classified, maybe subject to contract/clinical review.	_	_	_
	Medication Reminder Service Non-Face-To-Face; Per Month				
S5185	Medication nerminaer service from ruce to ruce, i et monen	Not subject to pre-service review.	_	_	_
	Personal Care Item Nos Each	Non Covered: Procedure/service not covered by the Plan.			
	rersonal care item 1403 Each	Not subject to pre-service review.			
S5199		Unlisted or Undefined: Procedures/services not specifically			
00100		defined or classified, maybe subject to contract/clinical	_	-	_
		review.			
	Home Infusion Therapy Catheter Care / Maintenance Not	i cricini			
	Otherwise Classified; Includes Administrative Services				
S5497	Professional Pharmacy Services Care Coordination And All	Unlisted: Procedure/service not specifically defined or			
	Necessary Supplies And Equipment (Drugs And Nursing	classified, maybe subject to contract/clinical review.	_	_	_
	Visits Coded Separately) Per Diem				
	Scleral Application Of Tantalum Ring(S) For Localization Of	MP Criteria: Procedures/services reviewed against Medical			
S8030	Lesions For Proton Beam Therapy	Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review by Carelon.	_	_	_
	Magnetic Source Imaging	MP Criteria: Procedure/service reviewed against Medical			
S8035		Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review.	_	_	_
	Magnetic Resonance Cholangiopancreatography (Mrcp)	MP Criteria: Procedures/services reviewed against Medical			
S8037		Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review by BCBS.	_	_	_
	Topographic Brain Mapping	MP Criteria: Procedure/service reviewed against Medical			
S8040		Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review.	3/1/2024	<u></u>	Add effective 03/01/2024
	Interferential Current Stimulator 2 Channel	EIU: Procedure/service not reimbursed by the Plan. Not			
S8130		subject to pre-service review. Check EIU policy, which is			
		one of our Clinical Payment and Coding Policy (CPCP).			
		one or our chinical rayment and county rolley (crer).			

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Add effective 04/01/2024
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	Home Infusion Therapy Infusion Therapy Not Otherwise				
	Classified; Administrative Services Professional Pharmacy	Unlisted: Procedure/service not specifically defined or			
S9379	Services Care Coordination And All Necessary Supplies And	classified, maybe subject to contract/clinical review.	_	_	_
	Equipment (Drugs And Nursing Visits Coded Separately) Per	classified, maybe subject to contract/cliffical review.			
	Diem				
50204	Delivery Or Service To High Risk Areas Requiring Escort Or	Non Covered: Procedure/service not covered by the Plan.			
S9381	Extra Protection Per Visit	Not subject to pre-service review.	-	-	-
50426	Childbirth Preparation/Lamaze Classes Non-Physician	Non Covered: Procedure/service not covered by the Plan.			
S9436	Provider Per Session	Not subject to pre-service review.	-	-	_
50.407	Childbirth Refresher Classes Non-Physician Provider Per	Non Covered: Procedure/service not covered by the Plan.			
S9437	Session	Not subject to pre-service review.	_	-	_
50.400	Cesarean Birth Classes Non-Physician Provider Per Session	Non Covered: Procedure/service not covered by the Plan.			
S9438		Not subject to pre-service review.	_	-	-
50.400	Vbac (Vaginal Birth After Cesarean) Classes Non-Physician	Non Covered: Procedure/service not covered by the Plan.			
S9439	Provider Per Session	Not subject to pre-service review.	_	-	-
50440	Birthing Classes Non-Physician Provider Per Session	Non Covered: Procedure/service not covered by the Plan.			
S9442		Not subject to pre-service review.	_	_	_
	Parenting Classes Non-Physician Provider Per Session	Non Covered: Procedure/service not covered by the Plan.			
S9444		Not subject to pre-service review.	_	_	_
	Patient Education Not Otherwise Classified Non-Physician	Unlisted: Procedure/service not specifically defined or			
S9445	Provider Individual Per Session	classified, maybe subject to contract/clinical review.	-	_	_
	Patient Education Not Otherwise Classified Non-Physician	Non Covered: Procedure/service not covered by the Plan.			
	Provider Group Per Session	Not subject to pre-service review.			
S9446		Unlisted or Undefined: Procedures/services not specifically			
		defined or classified, maybe subject to contract/clinical	_	_	_
		review.			
	Infant Safety (Including Cpr) Classes Non-Physician Provider				
S9447	Per Session	Not subject to pre-service review.	_	_	_
	Weight Management Classes Non-Physician Provider Per	Non Covered: Procedure/service not covered by the Plan.			
S9449	Session	Not subject to pre-service review.	_	_	_
	Exercise Classes Non-Physician Provider Per Session	Non Covered: Procedure/service not covered by the Plan.			
S9451	Exercise classes from Frysidan Frender Fer Session	Not subject to pre-service review.	_	_	_
	Stress Management Classes Non-Physician Provider Per	Non Covered: Procedure/service not covered by the Plan.			
S9454	Session	Not subject to pre-service review.	_	_	_
		MP Criteria: Procedure/service reviewed against Medical			
S9472	Diem	Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review.	_	_	-
	Family Stabilization Services Per 15 Minutes	Non Covered: Procedure/service not covered by the Plan.			
S9482		Not subject to pre-service review.	_	_	_
	Home Injectable Therapy Not Otherwise Classified				
	Including Administrative Services Professional Pharmacy				
S9542	Services Care Coordination And All Necessary Supplies And	Unlisted: Procedure/service not specifically defined or			
555 12	Equipment (Drugs And Nursing Visits Coded Separately) Per	classified, maybe subject to contract/clinical review.	-	-	_
	Diem				

Home Injectable Therapy; Growth Hormone Including Administrative Services Professional Pharmacy Services Care Coordination And All Necessary Supplies And Equipment (Drugs And Nursing Visits Coded Separately) Per Diem Home Injectable Therapy Palivizumab Or Other Monoclonal Antibody For Rsv Including Administrative Services Professional Pharmacy Services Care Coordination And All Necessary Supplies And Equipment (Drugs And Nursing Visits Coded Separately) Per Diem Home Therapy; Professional Pharmacy Services For Provision Of Infusion Specialty Drug Administration And/Or Disease State Management Not Otherwise Classified Per Hour (Do Not Use This Code With Any Per Diem Code) Services By A Journal-Listed Christian Science Practitioner For The Purpose of Healing Per Diem Not subject to pre-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria: Procedure/service reviewed. MP Criteria: Procedure/service reviewed against Medical Policy Criteria: Procedure/service reviewed against Medical Policy Criteria: Procedure/service reviewed. Unlisted: Procedure/service reviewed against Medical Policy Criteria: Procedure/service reviewed. Unlisted: Procedure/service reviewed against Medical Policy Criteria: Procedure/service reviewed. Unlisted: Procedure/service reviewed against Medical Policy Criteria: Procedure/service reviewed. Unlisted: Procedure/service reviewed against Medical Policy Criteria: Procedure/service reviewed against Medical Policy Criteria: Procedure/service reviewed. Unlisted: Procedure/service reviewed against Medical Policy Criteria: Procedure/service reviewed against Medical Policy Criteria: Procedure/service reviewed. Unlisted: Procedure/service reviewed against Medical Policy Criteria: Procedure/service reviewed against Medic	_
S9558 Care Coordination And All Necessary Supplies And Equipment (Drugs And Nursing Visits Coded Separately) Per Diem Home Injectable Therapy Palivizumab Or Other Monoclonal Antibody For Rsv Including Administrative Services Professional Pharmacy Services Care Coordination And All Necessary Supplies And Equipment (Drugs And Nursing Visits Coded Separately) Per Diem Home Therapy; Professional Pharmacy Services For Provision Of Infusion Specialty Drug Administration And/Or Disease State Management Not Otherwise Classified Per Hour (Do Not Use This Code With Any Per Diem Code) Services By A Journal-Listed Christian Science Practitioner For The Purpose Of Healing Per Diem Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. MP Criteria: Submit for Recommended Clinical Review to avoid post-service review. Unlisted: Procedure/service review. Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Services By A Journal-Listed Christian Science Practitioner For The Purpose Of Healing Per Diem Not subject to pre-service review.	_
Equipment (Drugs And Nursing Visits Coded Separately) Per Diem Home Injectable Therapy Palivizumab Or Other Monoclonal Antibody For Rsv Including Administrative Services Professional Pharmacy Services Care Coordination And All Necessary Supplies And Equipment (Drugs And Nursing Visits Coded Separately) Per Diem Home Therapy; Professional Pharmacy Services Care Coordination And All Necessary Supplies And Equipment (Drugs And Nursing Visits Coded Separately) Per Diem Home Therapy; Professional Pharmacy Services For Provision Of Infusion Specialty Drug Administration And/Or Disease State Management Not Otherwise Classified Per Hour (Do Not Use This Code With Any Per Diem Code) Services By A Journal-Listed Christian Science Practitioner For The Purpose Of Healing Per Diem Not subject to pre-service review. ### Avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. ### Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. ### Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. ### Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. ### Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. ### Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. ### Procedure/service not specifically defined or classified per Diem Not subject to pre-service not covered by the Plan. Not subject to pre-service review.	_
Diem Home Injectable Therapy Palivizumab Or Other Monoclonal Antibody For Rsv Including Administrative Services Professional Pharmacy Services Care Coordination And All Necessary Supplies And Equipment (Drugs And Nursing Visits Coded Separately) Per Diem Home Therapy; Professional Pharmacy Services For Provision Of Infusion Specialty Drug Administration And/Or Disease State Management Not Otherwise Classified Per Hour (Do Not Use This Code With Any Per Diem Code) Services By A Journal-Listed Christian Science Practitioner For The Purpose Of Healing Per Diem Not subject to pre-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Services By A Journal-Listed Christian Science Practitioner For The Purpose Of Healing Per Diem Not subject to pre-service reviewed.	_
Diem Home Injectable Therapy Palivizumab Or Other Monoclonal Antibody For Rsv Including Administrative Services Professional Pharmacy Services Care Coordination And All Necessary Supplies And Equipment (Drugs And Nursing Visits Coded Separately) Per Diem Home Therapy; Professional Pharmacy Services For Provision Of Infusion Specialty Drug Administration And/Or Disease State Management Not Otherwise Classified Per Hour (Do Not Use This Code With Any Per Diem Code) Services By A Journal-Listed Christian Science Practitioner For The Purpose Of Healing Per Diem Not subject to pre-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Services By A Journal-Listed Christian Science Practitioner For The Purpose Of Healing Per Diem Not subject to pre-service reviewed.	_
Home Injectable Therapy Palivizumab Or Other Monoclonal Antibody For Rsv Including Administrative Services Professional Pharmacy Services Care Coordination And All Necessary Supplies And Equipment (Drugs And Nursing Visits Coded Separately) Per Diem Home Therapy; Professional Pharmacy Services For Provision Of Infusion Specialty Drug Administration And/Or Disease State Management Not Otherwise Classified Per Hour (Do Not Use This Code With Any Per Diem Code) Services By A Journal-Listed Christian Science Practitioner For The Purpose Of Healing Per Diem Home Inferapy; Professional Pharmacy Services For Provision Of Infusion Specialty Drug Administration And/Or Classified, maybe subject to contract/clinical review. WP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to	_
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Professional Pharmacy Services Care Coordination And All Necessary Supplies And Equipment (Drugs And Nursing Visits Coded Separately) Per Diem Home Therapy; Professional Pharmacy Services For Provision Of Infusion Specialty Drug Administration And/Or Disease State Management Not Otherwise Classified Per Hour (Do Not Use This Code With Any Per Diem Code) Services By A Journal-Listed Christian Science Practitioner For The Purpose Of Healing Per Diem Professional Pharmacy Services Care Coordination And All Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_
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Visits Coded Separately) Per Diem Home Therapy; Professional Pharmacy Services For Provision Of Infusion Specialty Drug Administration And/Or Disease State Management Not Otherwise Classified Per Hour (Do Not Use This Code With Any Per Diem Code) Services By A Journal-Listed Christian Science Practitioner For The Purpose Of Healing Per Diem Visits Coded Separately) Per Diem Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_
Home Therapy; Professional Pharmacy Services For Provision Of Infusion Specialty Drug Administration And/Or Disease State Management Not Otherwise Classified Per Hour (Do Not Use This Code With Any Per Diem Code) Services By A Journal-Listed Christian Science Practitioner For The Purpose Of Healing Per Diem Services For Administration And/Or Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_
Provision Of Infusion Specialty Drug Administration And/Or Disease State Management Not Otherwise Classified Per Hour (Do Not Use This Code With Any Per Diem Code) Services By A Journal-Listed Christian Science Practitioner For The Purpose Of Healing Per Diem Provision Of Infusion Specialty Drug Administration And/Or Disease State Management Not Otherwise Classified Per Classified, maybe subject to contract/clinical review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	
Disease State Management Not Otherwise Classified Per Hour (Do Not Use This Code With Any Per Diem Code) Services By A Journal-Listed Christian Science Practitioner For The Purpose Of Healing Per Diem Services By A Journal-Listed Christian Science Practitioner Not subject to pre-service not covered by the Plan. Not subject to pre-service review.	
Disease State Management Not Otherwise Classified Per Hour (Do Not Use This Code With Any Per Diem Code) Services By A Journal-Listed Christian Science Practitioner For The Purpose Of Healing Per Diem Services By A Journal-Listed Christian Science Practitioner Not subject to pre-service review. Not subject to contract/clinical review.	-
Hour (Do Not Use This Code With Any Per Diem Code) Services By A Journal-Listed Christian Science Practitioner For The Purpose Of Healing Per Diem Not subject to pre-service review.	
For The Purpose Of Healing Per Diem Not subject to pre-service review.	
For The Purpose Of Healing Per Diem Not subject to pre-service review.	
For The Purpose Of Healing Per Diem Not subject to pre-service review.	
Health Club Marchardin Annual Non Coursel Decading from the plan	-
Health Club Membership Annual Non Covered: Procedure/service not covered by the Plan.	
Not subject to pre-service review.	-
Transplant Related Lodging Meals And Transportation Per Non Covered: Procedure/service not covered by the Plan	
S9975 Diem Not subject to pre-service review.	-
Lodging Per Diem Not Otherwise Classified Non Covered: Procedure/service not covered by the Plan.	
Not subject to pre-service review.	
S9976 Unlisted or Undefined: Procedures/services not specifically	
defined or classified, maybe subject to contract/clinical	-
review.	
Meals Per Diem Not Otherwise Specified Non Covered: Procedure/service not covered by the Plan.	
Not subject to pre-service review.	
S9977 Unlisted or Undefined: Procedures/services not specifically	-
defined or classified, maybe subject to contract/clinical	
review.	
S9981 Medical Records Copying Fee Administrative Non Covered: Procedure/service not covered by the Plan.	
Not subject to pre-service review.	-
S9982 Medical Records Copying Fee Per Page Non Covered: Procedure/service not covered by the Plan.	
Not subject to pre-service review.	-
S9986 Not Medically Necessary Service (Patient Is Aware That S9986	
Service Not Medically Necessary) Not subject to pre-service review. - - -	_
Services Provided As Part Of A Phase I Clinical Trial Non Covered: Procedure/service not covered by the Plan.	
Not subject to pre-service review.	-
Services Provided As Part Of A Phase Ii Clinical Trial Non Covered: Procedure/service not covered by the Plan.	
Not subject to pre-service review.	-
Services Provided As Part Of A Phase Iii Clinical Trial Non Covered: Procedure/service not covered by the Plan.	
Not subject to pre-service review.	-
Transportation Costs To And From Trial Location And Local	
Transportation Costs (F. G., Fares For Taxicah Or Bus) For Non Covered: Procedure/service not covered by the Plan.	
S9992 Clinical Trial Participant And One Caregiver/Companion Not subject to pre-service review.	-
Children That Farticipality And One Caregiver/ Companion	

	Lodging Costs (E. G. Hotel Charges) For Clinical Trial	Non Covered: Procedure/service not covered by the Plan.			
S9994	Participant And One Caregiver/Companion	Not subject to pre-service review.	_	_	-
50005	Meals For Clinical Trial Participant And One	Non Covered: Procedure/service not covered by the Plan.			
S9996	Caregiver/Companion	Not subject to pre-service review.	-	-	-
50000	Sales Tax	Non Covered: Procedure/service not covered by the Plan.			
S9999		Not subject to pre-service review.	-	-	-
T4044	Telehealth Transmission Per Minute Professional Services	Non Covered: Procedure/service not covered by the Plan.			
T1014	Bill Separately	Not subject to pre-service review.	-	-	-
	Electronic Medication Compliance Management Device	Unlisted: Procedure/service not specifically defined or			
T1505	Includes All Components And Accessories Not Otherwise	classified, maybe subject to contract/clinical review.	_	_	_
	Classified	classified, maybe subject to contract/cliffical review.			
	Miscellaneous Therapeutic Items And Supplies Retail	Unlisted: Procedure/service not specifically defined or			
T1999	Purchases Not Otherwise Classified; Identify Product In	classified, maybe subject to contract/clinical review.	_	_	_
	Remarks	classified, maybe subject to contract/cliffical review.			
T2012	Habilitation Educational; Waiver Per Diem	Unlisted: Procedure/service not specifically defined or			
12012		classified, maybe subject to contract/clinical review.	-	-	_
T2013	Habilitation Educational Waiver; Per Hour	Unlisted: Procedure/service not specifically defined or			
12015		classified, maybe subject to contract/clinical review.	-	-	-
T2014	Habilitation Prevocational Waiver; Per Diem	Unlisted: Procedure/service not specifically defined or			
12011		classified, maybe subject to contract/clinical review.	-	-	_
T2015	Habilitation Prevocational Waiver; Per Hour	Unlisted: Procedure/service not specifically defined or			
.1013		classified, maybe subject to contract/clinical review.	-	-	_
T2016	Habilitation Residential Waiver; Per Diem	Unlisted: Procedure/service not specifically defined or			
1-1-1		classified, maybe subject to contract/clinical review.	-	-	_
T2017	Habilitation Residential Waiver; 15 Minutes	Unlisted: Procedure/service not specifically defined or			
		classified, maybe subject to contract/clinical review.	_	-	_
T2018	Habilitation Supported Employment Waiver; Per Diem	Unlisted: Procedure/service not specifically defined or			
		classified, maybe subject to contract/clinical review.	_	_	_
T2019	Habilitation Supported Employment Waiver; Per 15	Unlisted: Procedure/service not specifically defined or			
	Minutes	classified, maybe subject to contract/clinical review.	_	_	_
T2020	Day Habilitation Waiver; Per Diem	Unlisted: Procedure/service not specifically defined or			
		classified, maybe subject to contract/clinical review.	_	_	_
T2021	Day Habilitation Waiver; Per 15 Minutes	Unlisted: Procedure/service not specifically defined or			
		classified, maybe subject to contract/clinical review.	_	_	_
T2024	Service Assessment/Plan Of Care Development Waiver	Unlisted: Procedure/service not specifically defined or			
		classified, maybe subject to contract/clinical review.	_		_
T2025	Waiver Services; Not Otherwise Specified (Nos)	Unlisted: Procedure/service not specifically defined or			
		classified, maybe subject to contract/clinical review.	_		_
T2026	Specialized Childcare Waiver; Per Diem	Unlisted: Procedure/service not specifically defined or	_		
	Constituted Oblider on Mark Constitution	classified, maybe subject to contract/clinical review.			
T2027	Specialized Childcare Waiver; Per 15 Minutes	Unlisted: Procedure/service not specifically defined or	_		
	Constalling of Consta	classified, maybe subject to contract/clinical review.			
T2028	Specialized Supply Not Otherwise Specified Waiver	Unlisted: Procedure/service not specifically defined or	_	_	
	Constitution I Admitted English College Constitution Cons	classified, maybe subject to contract/clinical review.			
T2029	Specialized Medical Equipment Not Otherwise Specified	Unlisted: Procedure/service not specifically defined or	_	_	_
	Waiver	classified, maybe subject to contract/clinical review.			

T2030	Assisted Living Waiver; Per Month	Unlisted: Procedure/service not specifically defined or			
12030		classified, maybe subject to contract/clinical review.	-	-	-
T2031	Assisted Living; Waiver Per Diem	Unlisted: Procedure/service not specifically defined or			
12031		classified, maybe subject to contract/clinical review.	-	-	-
T2032	Residential Care Not Otherwise Specified (Nos) Waiver; Per	Unlisted: Procedure/service not specifically defined or			
12032	Month	classified, maybe subject to contract/clinical review.	_	-	-
T2033	Residential Care Not Otherwise Specified (Nos) Waiver; Per	Unlisted: Procedure/service not specifically defined or			
12033	Diem	classified, maybe subject to contract/clinical review.	_	-	-
T2034	Crisis Intervention Waiver; Per Diem	Unlisted: Procedure/service not specifically defined or			
12054		classified, maybe subject to contract/clinical review.	_	-	-
T2035	Utility Services To Support Medical Equipment And Assistive	Unlisted: Procedure/service not specifically defined or			
12055	Technology/Devices Waiver	classified, maybe subject to contract/clinical review.	_	-	-
T2036	Therapeutic Camping Overnight Waiver; Each Session	Unlisted: Procedure/service not specifically defined or			
12030		classified, maybe subject to contract/clinical review.	_	-	-
T2037	Therapeutic Camping Day Waiver; Each Session	Unlisted: Procedure/service not specifically defined or			
12037		classified, maybe subject to contract/clinical review.	_	-	-
T2020	Community Transition Waiver; Per Service	Unlisted: Procedure/service not specifically defined or			
T2038		classified, maybe subject to contract/clinical review.	_	-	-
T2020	Vehicle Modifications Waiver; Per Service	Unlisted: Procedure/service not specifically defined or			
T2039		classified, maybe subject to contract/clinical review.	_	-	-
T2040	Financial Management Self-Directed Waiver; Per 15	Unlisted: Procedure/service not specifically defined or			
T2040	Minutes	classified, maybe subject to contract/clinical review.	_	-	-
T2044	Supports Brokerage Self-Directed Waiver; Per 15 Minutes	Unlisted: Procedure/service not specifically defined or			
T2041		classified, maybe subject to contract/clinical review.	_	-	-
T24.04	Human Breast Milk Processing Storage And Distribution	Non Covered: Procedure/service not covered by the Plan.			
T2101	Only	Not subject to pre-service review.	_	-	-
T5000	Supply Not Otherwise Specified	Unlisted: Procedure/service not specifically defined or			
T5999		classified, maybe subject to contract/clinical review.	_	-	-
\/2005	Deluxe Frame	Non Covered: Procedure/service not covered by the Plan.			
V2025		Not subject to pre-service review.	_	-	-
V/2400	Not Otherwise Classified Single Vision Lens	Unlisted: Procedure/service not specifically defined or			
V2199	_	classified, maybe subject to contract/clinical review.	_	-	-
	Contact Lens Other Type	Unlisted: Procedure/service not specifically defined or			
V2599	The state of the s	classified, maybe subject to contract/clinical review.	_	_	-
	Prosthetic Eye Other Type	Unlisted: Procedure/service not specifically defined or			
V2629	, , , ,	classified, maybe subject to contract/clinical review.	_	_	-
	Deluxe Lens Feature	Non Covered: Procedure/service not covered by the Plan.			
V2702		Not subject to pre-service review.	_	_	-
	Tint Photochromatic Per Lens	Non Covered: Procedure/service not covered by the Plan.			
V2744		Not subject to pre-service review.	_	_	-
	Astigmatism Correcting Function Of Intraocular Lens	MP Criteria: Procedure/service reviewed against Medical			
V2787		Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review.	_	_	[
	Presbyopia Correcting Function Of Intraocular Lens	MP Criteria: Procedure/service reviewed against Medical			
V2788		Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review.	_	_	-
	1	p			

	Vision Item Or Service Miscellaneous	Non Covered: Procedure/service not covered by the Plan.			
	VISION ITEM OF Service Wilscenarieous	Not subject to pre-service review.			
V2799		Unlisted or Undefined: Procedures/services not specifically			
V2733		defined or classified, maybe subject to contract/clinical	_	-	_
		review.			
	Dispensing Fee Unspecified Hearing Aid	Unlisted: Procedure/service not specifically defined or			
V5090	Dispensing recompenied rearing rud	classified, maybe subject to contract/clinical review.	_	_	_
	Semi-Implantable Middle Ear Hearing Prosthesis	MP Criteria: Procedure/service reviewed against Medical			
V5095		Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review.	_	_	-
	Hearing Aid Or Assistive Listening	Unlisted: Procedure/service not specifically defined or			
V5267	Device/Supplies/Accessories Not Otherwise Specified	classified, maybe subject to contract/clinical review.	_	_	_
	Assistive Listening Device Not Otherwise Specified	Unlisted: Procedure/service not specifically defined or			
V5274		classified, maybe subject to contract/clinical review.	_	-	_
VE207	Assistive Listening Device Personal Fm/Dm Receiver Not	Unlisted: Procedure/service not specifically defined or			
V5287	Otherwise Specified	classified, maybe subject to contract/clinical review.	-	-	-
VE 200	Hearing Aid Not Otherwise Classified	Unlisted: Procedure/service not specifically defined or			
V5298		classified, maybe subject to contract/clinical review.	-	-	-
V5299	Hearing Service Miscellaneous	Unlisted: Procedure/service not specifically defined or			
V5299		classified, maybe subject to contract/clinical review.	_	-	-
	Speech Screening	MP Criteria: Procedure/service reviewed against Medical			
V5362		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Language Screening	MP Criteria: Procedure/service reviewed against Medical			
V5363		Policy Criteria. Submit for Recommended Clinical Review to	_	_	_
		avoid post-service review.			
	Ablation Therapy For Reduction Or Eradication Of 1 Or More				
	Bone Tumors (Eg Metastasis) Including Adjacent Soft Tissue				
20982	When Involved By Tumor Extension Percutaneous Including	Policy Criteria. Submit for Recommended Clinical Review to		_	
	Imaging Guidance When Performed; Radiofrequency	avoid post-service review.			
			6/1/2024		Add effective 06/01/2024
	Laparoscopy Surgical; Ablation Of Renal Cysts	MP Criteria: Procedure/service reviewed against Medical			
50541		Policy Criteria. Submit for Recommended Clinical Review to		_	
		avoid post-service review.	6/1/2024		Add effective 06/01/2024
	Laparoscopy Surgical; Ablation Of Renal Mass Lesion(S)	MP Criteria: Procedure/service reviewed against Medical			
50542	Including Intraoperative Ultrasound Guidance And	Policy Criteria. Submit for Recommended Clinical Review to	6/4/2024	_	A d d = \$5 - 45 - 4 05 /04 /2024
	Monitoring When Performed	avoid post-service review.	6/1/2024		Add effective 06/01/2024
00507	Externally Applied Transcranial Magnetic Stimulation With	MP Criteria: Procedure/service reviewed against Medical			
0858T	Concomitant Measurement Of Evoked Cortical Potentials	Policy Criteria. Submit for Recommended Clinical Review to		-	Add affaation 05/01/2024
	With Automated Report Oncology (bladder), methylated PENK DNA detection by	avoid post-service review. MP Criteria: Procedure/service reviewed against Medical	6/1/2024		Add effective 06/01/2024
		_			
0452U	linear target enrichment-quantitative methylation-specific	Policy Criteria. Submit for Recommended Clinical Review to		_	
	real-time PCR (LTE-qMSP), urine, reported as likelihood of	avoid post-service review. Prior Authorization may be	10/1/2024		Add effective 10/1/2024
	bladder cancer	required per contract agreement.	10/1/2024		Add ellective 10/1/2024

	Oncology (colorectal cancer), cellfree DNA (cfDNA),	MP Criteria: Procedure/service reviewed against Medical			
0453U	methylation-based quantitative PCR assay (SEPTIN9, IKZF1,	Policy Criteria. Submit for Recommended Clinical Review to			
0.1330	BCAT1, Septin9-2, VAV3, BCAN), plasma, reported as	avoid post-service review. Prior Authorization may be		_	
	presence or absence of circulating tumor DNA (ctDNA)	required per contract agreement.	10/1/2024		Add effective 10/1/2024
	Rare diseases (constitutional/heritable disorders),	MP Criteria: Procedure/service reviewed against Medical			
0454U	identification of copy number variations, inversions,	Policy Criteria. Submit for Recommended Clinical Review to			
04340	insertions, translocations, and other structural variants by	avoid post-service review. Prior Authorization may be		-	
	optical genome mapping	required per contract agreement.	10/1/2024		Add effective 10/1/2024
		MP Criteria: Procedure/service reviewed against Medical			
	Autoimmune (rheumatoid arthritis), next-generation	Policy Criteria. Submit for Recommended Clinical Review to			
	sequencing (NGS), gene expression testing of 19 genes,	avoid post-service review. Prior Authorization may be			
		required per contract agreement.			
0456U	whole blood, with analysis of anti-cyclic citrullinated	MP Criteria: Procedure/service reviewed against Medical		_	
	peptides (CCP) levels, combined with sex, patient global	Policy Criteria. Submit for Recommended Clinical Review to			
	assessment, and body mass index (BMI), algorithm reported	· ·			
	as a score that predicts nonresponse to tumor necrosis	avoid post-service review. Prior Authorization may be			
	factor inhibitor (TNFi) therapy	required per contract agreement.	10/1/2024		Add effective 10/1/2024
	Oncology, whole blood or buccal, DNA single-nucleotide	MP Criteria: Procedure/service reviewed against Medical			
046011		Policy Criteria. Submit for Recommended Clinical Review to			
0460U	polymorphism (SNP) genotyping by real-time PCR of 24	avoid post-service review. Prior Authorization may be		-	
	genes, with variant analysis and reported phenotypes	required per contract agreement.	10/1/2024		Add effective 10/1/2024
	Oncology, pharmacogenomic analysis of single-nucleotide	MP Criteria: Procedure/service reviewed against Medical			
	polymorphism (SNP) genotyping by real-time PCR of 24	Policy Criteria. Submit for Recommended Clinical Review to			
0461U	genes, whole blood or buccal swab, with variant analysis,	*		_	
	including impacted gene-drug interactions and reported	avoid post-service review. Prior Authorization may be			
	phenotypes	required per contract agreement.	10/1/2024		Add effective 10/1/2024
	Oncology (urothelial carcinoma), DNA, quantitative	MP Criteria: Procedure/service reviewed against Medical			
046511		Policy Criteria. Submit for Recommended Clinical Review to			
0465U	methylation-specific PCR of 2 genes (ONECUT2, VIM),	avoid post-service review. Prior Authorization may be		_	
	algorithmic analysis reported as positive or negative	required per contract agreement.	10/1/2024		Add effective 10/1/2024
	Cardiology (coronary artery disease [CAD]), DNA, genome-	MP Criteria: Procedure/service reviewed against Medical			
	wide association studies (564856 single-nucleotide	Policy Criteria. Submit for Recommended Clinical Review to			
0466U	polymorphisms [SNPs], targeted variant genotyping), patient	*			
	lifestyle and clinical data, buccal swab, algorithm reported as	avoid post-service review. Prior Authorization may be			
	polygenic risk to acquired heart disease	required per contract agreement.	10/1/2024		Add effective 10/1/2024
	Oncology (bladder), DNA, next-generation sequencing (NGS)	MD Critoria: Procedure /convice reviewed against Medical			
0467U	of 60 genes and whole genome aneuploidy, urine,	Policy Criteria. Submit for Recommended Clinical Review to			
	algorithms reported as minimal residual disease (MRD)	avoid post-service review. Prior Authorization may be			
	status positive or negative and quantitative disease burden	required per contract agreement.	10/1/2024		Add effective 10/1/2024
					7.7.

0469U	Rare diseases (constitutional/heritable disorders), whole genome sequence analysis for chromosomal abnormalities, copy number variants, duplications/deletions, inversions, unbalanced translocations, regions of homozygosity (ROH), inheritance pattern that indicate uniparental disomy (UPD), and aneuploidy, fetal sample (amniotic fluid, chorionic villus sample, or products of conception), identification and categorization of genetic variants, diagnostic report of fetal results based on phenotype with maternal sample and paternal sample, if performed, as comparators and/or maternal cell contamination	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	10/1/2024	_	Add effective 10/1/2024
0471U	Oncology (colorectal cancer), qualitative real-time PCR of 35 variants of KRAS and NRAS genes (exons 2, 3, 4), formalin-fixed paraffin-embedded (FFPE), predictive, identification of detected mutations	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	10/1/2024	-	Add effective 10/1/2024
0473U	Oncology (solid tumor), next-generation sequencing (NGS) of DNA from formalin-fixed paraffin-embedded (FFPE) tissue with comparative sequence analysis from a matched normal specimen (blood or saliva), 648 genes, interrogation for sequence variants, insertion and deletion alterations, copy number variants, rearrangements, microsatellite instability, and tumor-mutation burden	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	10/1/2024	_	Add effective 10/1/2024
0474U	Hereditary pan-cancer (eg, hereditary sarcomas, hereditary endocrine tumors, hereditary neuroendocrine tumors, hereditary cutaneous melanoma), genomic sequence analysis panel of 88 genes with 20 duplications/deletions using next-generation sequencing (NGS), Sanger sequencing, blood or saliva, reported as positive or negative for germline variants, each gene	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	10/1/2024	-	Add effective 10/1/2024
0475U	Hereditary prostate cancer-related disorders, genomic sequence analysis panel using next-generation sequencing (NGS), Sanger sequencing, multiplex ligation-dependent probe amplification (MLPA), and array comparative genomic hybridization (CGH), evaluation of 23 genes and duplications/deletions when indicated, pathologic mutations reported with a genetic risk score for prostate cancer	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	10/1/2024	_	Add effective 10/1/2024
0020M	Oncology (central nervous system), analysis of 30000 DNA methylation loci by methylation array, utilizing DNA extracted from tumor tissue, diagnostic algorithm reported as probability of matching a reference tumor subclass	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	10/1/2024	-	Add effective 10/1/2024

J3263	Loqtorzi (toripalimab-tpzi)	MP Criteria: Procedure/service reviewed against Medical			
		Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review. Prior Authorization may be		_	
		required per contract agreement.			
	Ryzneuta (efbemalenograstim alfa-vuxw)	MP Criteria: Procedure/service reviewed against Medical			
J9361		Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review. Prior Authorization may be		_	
		required per contract agreement.			
	Injection Bevacizumab 10 Mg	MP Criteria: Procedure/service reviewed against Medical			
J9035		Policy Criteria. Submit for Recommended Clinical Review to			
13033		avoid post-service review. Prior Authorization may be	_	_	
		required per contract agreement.			
	Injection Bevacizumab 0.25 Mg	MP Criteria: Procedure/service reviewed against Medical			
C9257		Policy Criteria. Submit for Recommended Clinical Review to			
C3237		avoid post-service review. Prior Authorization may be	_		
		required per contract agreement.		10/1/2024	Retire effective 10/1/2024
		MP Criteria: Procedure/service reviewed against Medical			
J0565	Injection Bezlotoxumab 10 Mg	Policy Criteria. Submit for Recommended Clinical Review to			
10303	Illjection Beziotoxumab 10 Mg	avoid post-service review. Prior Authorization may be	_		
		required per contract agreement.		10/1/2024	Retire effective 10/1/2024
	Injection Histrelin Acetate 10 Micrograms	MP Criteria: Procedure/service reviewed against Medical			
11.675		Policy Criteria. Submit for Recommended Clinical Review to			
J1675		avoid post-service review. Prior Authorization may be	_		
		required per contract agreement.		10/1/2024	Retire effective 10/1/2024
	Injection Leuprolide Acetate (For Depot Suspension) Per 3. 75 Mg	MP Criteria: Procedure/service reviewed against Medical			
11050		Policy Criteria. Submit for Recommended Clinical Review to			
J1950		avoid post-service review. Prior Authorization may be	_		
		required per contract agreement.		10/1/2024	Retire effective 10/1/2024
	Injection Ziconotide 1 Microgram	MP Criteria: Procedure/service reviewed against Medical			
		Policy Criteria. Submit for Recommended Clinical Review to			
J2278		avoid post-service review. Prior Authorization may be	_		
		required per contract agreement.		10/1/2024	Retire effective 10/1/2024
	Injection Pasireotide Long Acting 1 Mg	MP Criteria: Procedure/service reviewed against Medical			
		Policy Criteria. Submit for Recommended Clinical Review to			
J2502		avoid post-service review. Prior Authorization may be	_		
		required per contract agreement.		10/1/2024	Retire effective 10/1/2024
J3121	Injection Testosterone Enanthate 1Mg	MP Criteria: Procedure/service reviewed against Medical			
		Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review. Prior Authorization may be	_		
		required per contract agreement.		10/1/2024	Retire effective 10/1/2024
J3145	Injection Testosterone Undecanoate 1 Mg	MP Criteria: Procedure/service reviewed against Medical			
		Policy Criteria. Submit for Recommended Clinical Review to			
		avoid post-service review. Prior Authorization may be	_		
		required per contract agreement.		10/1/2024	Retire effective 10/1/2024
		required per contract agreements		= 0, 2, 202 .	

		MP Criteria: Procedure/service reviewed against Medical		
J3285	Injection Treprostinil 1 Mg	_		
		Policy Criteria. Submit for Recommended Clinical Review to	_	
		avoid post-service review. Prior Authorization may be	10/1/20	24 Patina officiation 10/1/2024
		required per contract agreement.	10/1/20	24 Retire effective 10/1/2024
		MP Criteria: Procedure/service reviewed against Medical		
J3315	Injection Triptorelin Pamoate 3. 75 Mg	Policy Criteria. Submit for Recommended Clinical Review to		
		avoid post-service review. Prior Authorization may be		
		required per contract agreement.	10/1/20	24 Retire effective 10/1/2024
	Injection Human Fibrinogen Concentrate Not Otherwise Specified 1 Mg	MP Criteria: Procedure/service reviewed against Medical		
J7178		Policy Criteria. Submit for Recommended Clinical Review to		
		avoid post-service review. Prior Authorization may be	-	
		required per contract agreement.	10/1/20	24 Retire effective 10/1/2024
	Carbidopa 5 Mg/Levodopa 20 Mg Enteral Suspension 100 Ml	MP Criteria: Procedure/service reviewed against Medical		
J7340		Policy Criteria. Submit for Recommended Clinical Review to		
		avoid post-service review. Prior Authorization may be	-	
		required per contract agreement.	10/1/20	24 Retire effective 10/1/2024
		MP Criteria: Procedure/service reviewed against Medical		
10155	Inication Decomplic 4 Ma	Policy Criteria. Submit for Recommended Clinical Review to		
J9155	Injection Degarelix 1 Mg	avoid post-service review. Prior Authorization may be	-	
		required per contract agreement.	10/1/20	24 Retire effective 10/1/2024
	Goserelin Acetate Implant Per 3. 6 Mg	MP Criteria: Procedure/service reviewed against Medical		
		Policy Criteria. Submit for Recommended Clinical Review to		
J9202		avoid post-service review. Prior Authorization may be	_	
		required per contract agreement.	10/1/20	24 Retire effective 10/1/2024
		MP Criteria: Procedure/service reviewed against Medical		
	Leuprolide Acetate (For Depot Suspension) 7. 5 Mg	Policy Criteria. Submit for Recommended Clinical Review to		
J9217		avoid post-service review. Prior Authorization may be	_	
		required per contract agreement.	10/1/20	24 Retire effective 10/1/2024
J9218	Leuprolide Acetate Per 1 Mg	MP Criteria: Procedure/service reviewed against Medical	7,7	
		Policy Criteria. Submit for Recommended Clinical Review to		
		avoid post-service review. Prior Authorization may be	_	
		required per contract agreement.	10/1/20	24 Retire effective 10/1/2024
		MP Criteria: Procedure/service reviewed against Medical	10/1/20	2 i Redire effective 10/1/2021
J9219	Leuprolide Acetate Implant 65 Mg	Policy Criteria. Submit for Recommended Clinical Review to		
		avoid post-service review. Prior Authorization may be	_	
			10/1/20	24 Retire effective 10/1/2024
J9225	Histrelin Implant (Vantas) 50 Mg	required per contract agreement. MP Criteria: Procedure/service reviewed against Medical	10/1/20	24 Retire effective 10/1/2024
		Policy Criteria. Submit for Recommended Clinical Review to		
		avoid post-service review. Prior Authorization may be	_	
			10/1/20	24 Retire effective 10/1/2024
		required per contract agreement.	10/1/20	24 Netire effective 10/1/2024
J9226	Histrelin Implant (Supprelin La) 50 Mg	MP Criteria: Procedure/service reviewed against Medical		
		Policy Criteria. Submit for Recommended Clinical Review to		
		avoid post-service review. Prior Authorization may be		0.4 0.4 /0.5 1
		required per contract agreement.	10/1/20	24 Retire effective 10/1/2024

S0157	Becaplermin Gel 0. 01% 0. 5 Gm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be	
		required per contract agreement.	10/1/2024 Retire effective 10/1/2024
S0189	Testosterone Pellet 75Mg	MP Criteria: Procedure/service reviewed against Medical	
		Policy Criteria. Submit for Recommended Clinical Review to	
		avoid post-service review. Prior Authorization may be	
		required per contract agreement.	10/1/2024 Retire effective 10/1/2024

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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 New Mexico (BCBSNM). For other services/members, BCBSNM 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 BCBSNM members. Obtaining prior authorization is not a substitute for checking eligibility and benefits.

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