BlueCross BlueShield of New Mexico

# 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:<br>- PPO℠<br>-Blue Preferred EPO<br>-Blue Preferred Plus<br>-HMO | Utilization Management Process<br><br>This file is a searchable PDF.<br>Press "CTRL" and "F" keys at the same time to bring up the search box. Enter a procedure code or description of the service. |
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| Procedure Code Groups | Procedure Code Group Description |
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| Medical Policy Criteria (MP Criteria) | Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.<br>Highlighted procedure/service in this code group may require Prior Authorization per contract agreement. |
| Non Covered | Procedures/services not covered by the Plan. Not subject to pre-service review. |
| Experimental, Investigational, Unproven (EIU) | Procedures/services not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). |
| Unlisted or Undefined | Procedures/services not specifically defined or classified, may be subject to contract/clinical review. |

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

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date | Updates |
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| 00640 | Anesthesia For Manipulation Of The Spine Or For Closed Procedures On The Cervical Thoracic Or Lumbar Spine | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 00797 | Anesthesia For Intraperitoneal Procedures In Upper Abdomen Including Laparoscopy; Gastric Restrictive Procedure For Morbid Obesity | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 07957 | Weight Loss | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| 11200 | Removal Of Skin Tags Multiple Fibrocutaneous Tags Any Area; Up To And Including 15 Lesions | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| 11201 | Removal Of Skin Tags Multiple Fibrocutaneous Tags Any Area; Each Additional 10 Lesions Or Part Thereof (List Separately In Addition To Code For Primary Procedure) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |

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| 11920 | Tattooing Intradermal Introduction Of Insoluble Opaque Pigments To Correct Color Defects Of Skin Including Micropigmentation; 6.0 Sq Cm Or Less | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 11921 | Tattooing Intradermal Introduction Of Insoluble Opaque Pigments To Correct Color Defects Of Skin Including Micropigmentation; 6.1 To 20.0 Sq Cm | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 11922 | Tattooing Intradermal Introduction Of Insoluble Opaque Pigments To Correct Color Defects Of Skin Including Micropigmentation; Each Additional 20.0 Sq Cm 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. | _ | _ | _ |
| 11950 | Subcutaneous Injection Of Filling Material (Eg Collagen); 1 Cc Or Less | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 11951 | Subcutaneous Injection Of Filling Material (Eg Collagen); 1.1 To 5.0 Cc | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 11952 | Subcutaneous Injection Of Filling Material (Eg Collagen); 5.1 To 10.0 Cc | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 11954 | Subcutaneous Injection Of Filling Material (Eg Collagen); Over 10.0 Cc | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 11960 | Insertion Of Tissue Expander(S) For Other Than Breast Including Subsequent Expansion | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 11970 | Replacement Of Tissue Expander With Permanent Implant | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 11980 | Subcutaneous Hormone Pellet Implantation (Implantation Of Estradiol And/Or Testosterone Pellets Beneath The Skin) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 15271 | Application Of Skin Substitute Graft To Trunk Arms Legs 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. | _ | _ | _ |
| 15272 | Application Of Skin Substitute Graft To Trunk Arms Legs 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. | _ | _ | _ |
| 15273 | Application Of 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. | _ | _ | _ |

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| 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. | _ | _ | _ |

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| 15776 | Punch Graft For Hair Transplant; More Than 15 Punch Grafts | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 15780 | Dermabrasion; Total Face (Eg For Acne Scarring Fine Wrinkling Rhytids General Keratosis) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 15781 | Dermabrasion; Segmental Face | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 15782 | Dermabrasion; Regional Other Than Face | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 15783 | Dermabrasion; Superficial Any Site (Eg Tattoo Removal) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 15786 | Abrasion; Single Lesion (Eg Keratosis Scar) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 15787 | Abrasion; Each Additional 4 Lesions Or Less (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. | _ | _ | _ |
| 15788 | Chemical Peel Facial; Epidermal | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 15789 | Chemical Peel Facial; Dermal | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 15792 | Chemical Peel Nonfacial; Epidermal | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 15793 | Chemical Peel Nonfacial; Dermal | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 15820 | Blepharoplasty Lower Eyelid; | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 15821 | Blepharoplasty Lower Eyelid; With Extensive Herniated Fat Pad | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 15822 | Blepharoplasty Upper Eyelid; | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 15823 | Blepharoplasty Upper Eyelid; With Excessive Skin Weighting Down Lid | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |

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

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

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

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

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| 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 | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 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 | Manipulation Of Temporomandibular Joint(S) (Tmj) Therapeutic Requiring An Anesthesia Service (Ie General Or Monitored Anesthesia Care) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to 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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| 21085 | Impression And Custom Preparation; Oral Surgical Splint | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to 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. | _ | _ | _ |
| 21110 | Application Of Interdental Fixation Device For Conditions Other Than Fracture Or Dislocation Includes Removal | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 21120 | Genioplasty; Augmentation (Autograft Allograft Prosthetic Material) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 21121 | Genioplasty; Sliding Osteotomy Single Piece | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 21122 | Genioplasty; Sliding Osteotomies 2 Or More Osteotomies (Eg Wedge Excision Or Bone Wedge Reversal For Asymmetrical Chin) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 21123 | Genioplasty; Sliding Augmentation With Interpositional Bone Grafts (Includes Obtaining Autografts) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 21125 | Augmentation Mandibular Body Or Angle; Prosthetic Material | 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. | _ | 4/14/2024 | Retire effective 04/14/2024 |
| 21127 | Augmentation Mandibular Body Or Angle; With Bone Graft Onlay Or Interpositional (Includes Obtaining Autograft) | 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. | _ | 4/14/2024 | Retire effective 04/14/2024 |
| 21141 | Reconstruction Midface Lefort I; Single Piece Segment Movement In Any Direction (Eg For Long Face Syndrome) Without Bone Graft | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 21142 | Reconstruction Midface Lefort I; 2 Pieces Segment Movement In Any Direction Without Bone Graft | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 21143 | Reconstruction Midface Lefort I; 3 Or More Pieces Segment Movement In Any Direction Without Bone Graft | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 21145 | Reconstruction Midface Lefort I; Single Piece Segment Movement In Any Direction Requiring Bone Grafts (Includes Obtaining Autografts) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | _ | _ | _ |
| 21146 | Reconstruction Midface Lefort I; 2 Pieces Segment Movement In Any Direction Requiring Bone Grafts (Includes Obtaining Autografts) (Eg Ungrafted Unilateral Alveolar Cleft) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | _ | _ | _ |

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| 21147 | Reconstruction Midface Lefort I; 3 Or More Pieces Segment Movement In Any Direction Requiring Bone Grafts (Includes Obtaining Autografts) (Eg Ungrafted Bilateral Alveolar Cleft Or Multiple Osteotomies) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | _ | _ | _ |
| 21150 | Reconstruction Midface Lefort Ii; Anterior Intrusion (Eg Treacher-Collins Syndrome) | 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. | _ | _ | _ |
| 21151 | Reconstruction Midface Lefort Ii; Any Direction Requiring Bone Grafts (Includes Obtaining Autografts) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | _ | _ | _ |
| 21154 | Reconstruction Midface Lefort Iii (Extracranial) Any Type Requiring Bone Grafts (Includes Obtaining Autografts); Without Lefort I | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | _ | _ | _ |
| 21155 | Reconstruction Midface Lefort Iii (Extracranial) Any Type Requiring Bone Grafts (Includes Obtaining Autografts); With Lefort I | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | _ | _ | _ |
| 21159 | Reconstruction Midface Lefort Iii (Extra And Intracranial) With Forehead Advancement (Eg Mono Bloc) Requiring Bone Grafts (Includes Obtaining Autografts); Without Lefort I | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | _ | _ | _ |
| 21160 | Reconstruction Midface Lefort Iii (Extra And Intracranial) With Forehead Advancement (Eg Mono Bloc) Requiring Bone Grafts (Includes Obtaining Autografts); With Lefort I | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | _ | _ | _ |
| 21188 | Reconstruction Midface Osteotomies (Other Than Lefort Type) And Bone Grafts (Includes Obtaining Autografts) | 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. | _ | _ | _ |
| 21193 | Reconstruction Of Mandibular Rami Horizontal Vertical C Or L Osteotomy; Without Bone Graft | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 21194 | Reconstruction Of Mandibular Rami Horizontal Vertical C Or L Osteotomy; With Bone Graft (Includes Obtaining Graft) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 21195 | Reconstruction Of Mandibular Rami And/Or Body Sagittal Split; Without Internal Rigid Fixation | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 21196 | Reconstruction Of Mandibular Rami And/Or Body Sagittal Split; With Internal Rigid Fixation | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 21198 | Osteotomy Mandible Segmental; | 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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| 21199 | Osteotomy Mandible Segmental; With Genioglossus Advancement | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 21206 | Osteotomy Maxilla Segmental (Eg Wassmund Or Schuchard) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | _ | _ | _ |
| 21208 | Osteoplasty Facial Bones; Augmentation (Autograft Allograft Or Prosthetic Implant) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | _ | _ | _ |
| 21209 | Osteoplasty Facial Bones; Reduction | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | _ | _ | _ |
| 21210 | Graft Bone; Nasal Maxillary Or Malar Areas (Includes Obtaining Graft) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 21215 | Graft Bone; Mandible (Includes Obtaining Graft) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 21230 | Graft; Rib Cartilage Autogenous To Face Chin Nose Or Ear (Includes Obtaining Graft) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 21244 | Reconstruction Of Mandible Extraoral With Transosteal Bone Plate (Eg Mandibular Staple Bone Plate) | 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 |
| 21245 | Reconstruction Of Mandible Or Maxilla Subperiosteal Implant; Partial | 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 |
| 21246 | Reconstruction Of Mandible Or Maxilla Subperiosteal Implant; Complete | 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 |
| 21248 | Reconstruction Of Mandible Or Maxilla Endosteal Implant (Eg Blade Cylinder); Partial | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| 21249 | Reconstruction Of Mandible Or Maxilla Endosteal Implant (Eg Blade Cylinder); Complete | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| 21299 | Unlisted Craniofacial And Maxillofacial Procedure | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| 21499 | Unlisted Musculoskeletal Procedure Head | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| 21685 | Hyoid Myotomy And Suspension | MP Criteria: Procedure/service reviewed against Medical 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. | _ | _ | _ |

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| 22206 | Osteotomy Of Spine Posterior Or Posterolateral Approach 3 Columns 1 Vertebral Segment (Eg Pedicle/Vertebral Body Subtraction); Thoracic | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 22207 | Osteotomy Of Spine Posterior Or Posterolateral Approach 3 Columns 1 Vertebral Segment (Eg Pedicle/Vertebral Body Subtraction); Lumbar | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 22208 | Osteotomy Of Spine Posterior Or Posterolateral Approach 3 Columns 1 Vertebral Segment (Eg Pedicle/Vertebral Body Subtraction); 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. | _ | _ | _ |
| 22210 | Osteotomy Of Spine Posterior Or Posterolateral Approach 1 Vertebral Segment; Cervical | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 22212 | Osteotomy Of Spine Posterior Or Posterolateral Approach 1 Vertebral Segment; Thoracic | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 22214 | Osteotomy Of Spine Posterior Or Posterolateral Approach 1 Vertebral Segment; Lumbar | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 22216 | Osteotomy Of Spine Posterior Or Posterolateral Approach 1 Vertebral Segment; Each Additional Vertebral Segment (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 Carelon. | _ | _ | _ |
| 22220 | Osteotomy Of Spine Including Discectomy Anterior Approach 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. | _ | _ | _ |
| 22222 | Osteotomy Of Spine Including Discectomy Anterior Approach 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. | _ | _ | _ |
| 22224 | Osteotomy Of Spine Including Discectomy Anterior Approach 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. | _ | _ | _ |
| 22226 | Osteotomy Of Spine Including Discectomy Anterior Approach Single Vertebral Segment; 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. | _ | _ | _ |
| 22505 | Manipulation Of Spine Requiring Anesthesia Any Region | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 22510 | Percutaneous Vertebroplasty (Bone Biopsy Included When Performed) 1 Vertebral Body Unilateral Or Bilateral Injection Inclusive Of All Imaging Guidance; Cervicothoracic | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 22511 | Percutaneous Vertebroplasty (Bone Biopsy Included When Performed) 1 Vertebral Body Unilateral Or Bilateral Injection Inclusive Of All Imaging Guidance; Lumbosacral | 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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| 22512 | Percutaneous Vertebroplasty (Bone Biopsy Included When Performed) 1 Vertebral Body Unilateral Or Bilateral Injection Inclusive Of All Imaging Guidance; Each Additional Cervicothoracic Or Lumbosacral Vertebral Body (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. | _ | _ | _ |
| 22513 | Percutaneous Vertebral Augmentation Including Cavity Creation (Fracture Reduction And Bone Biopsy Included When Performed) Using Mechanical Device (Eg Kyphoplasty) 1 Vertebral Body Unilateral Or Bilateral Cannulation Inclusive Of All Imaging Guidance; Thoracic | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 22514 | Percutaneous Vertebral Augmentation Including Cavity Creation (Fracture Reduction And Bone Biopsy Included When Performed) Using Mechanical Device (Eg Kyphoplasty) 1 Vertebral Body Unilateral Or Bilateral Cannulation Inclusive Of All Imaging Guidance; Lumbar | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 22515 | Percutaneous Vertebral Augmentation Including Cavity Creation (Fracture Reduction And Bone Biopsy Included When Performed) Using Mechanical Device (Eg Kyphoplasty) 1 Vertebral Body Unilateral Or Bilateral Cannulation Inclusive Of All Imaging Guidance; Each Additional Thoracic Or Lumbar Vertebral Body (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. | _ | _ | _ |
| 22526 | Percutaneous Intradiscal Electrothermal Annuloplasty Unilateral Or Bilateral Including Fluoroscopic Guidance; Single Level | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| 22527 | Percutaneous Intradiscal Electrothermal Annuloplasty Unilateral Or Bilateral Including Fluoroscopic Guidance; 1 Or More Additional Levels (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). | _ | _ | _ |
| 22532 | Arthrodesis Lateral Extracavitary Technique Including Minimal Discectomy To Prepare Interspace (Other Than For Decompression); Thoracic | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 22533 | Arthrodesis Lateral Extracavitary Technique Including Minimal Discectomy To Prepare Interspace (Other Than For Decompression); Lumbar | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 22534 | Arthrodesis Lateral Extracavitary Technique Including Minimal Discectomy To Prepare Interspace (Other Than For Decompression); Thoracic Or 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. | _ | _ | _ |
| 22548 | Arthrodesis Anterior Transoral Or Extraoral Technique Clivus-C1-C2 (Atlas-Axis) With Or Without Excision Of Odontoid Process | 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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| 22551 | Arthrodesis Anterior Interbody Including Disc Space Preparation Discectomy Osteophytectomy And Decompression Of Spinal Cord And/Or Nerve Roots; Cervical Below C2 | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 22552 | Arthrodesis Anterior Interbody Including Disc Space Preparation Discectomy Osteophytectomy And Decompression Of Spinal Cord And/Or Nerve Roots; Cervical Below C2 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. | _ | _ | _ |
| 22554 | Arthrodesis Anterior Interbody Technique Including Minimal Discectomy To Prepare Interspace (Other Than For Decompression); Cervical Below C2 | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 22556 | Arthrodesis Anterior Interbody Technique Including Minimal Discectomy To Prepare Interspace (Other Than For Decompression); Thoracic | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 22558 | Arthrodesis Anterior Interbody Technique Including Minimal Discectomy To Prepare Interspace (Other Than For Decompression); Lumbar | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 22585 | Arthrodesis Anterior Interbody Technique Including Minimal Discectomy To Prepare Interspace (Other Than For Decompression); 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. | _ | _ | _ |
| 22586 | Arthrodesis Pre-Sacral Interbody Technique Including Disc Space Preparation Discectomy With Posterior Instrumentation With Image Guidance Includes Bone Graft When Performed L5-S1 Interspace | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| 22590 | Arthrodesis Posterior Technique Craniocervical (Occiput-C2) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 22595 | Arthrodesis Posterior Technique Atlas-Axis (C1-C2) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 22600 | Arthrodesis Posterior Or Posterolateral Technique Single Interspace; Cervical Below C2 Segment | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 22610 | Arthrodesis Posterior Or Posterolateral Technique Single Interspace; Thoracic (With Lateral Transverse Technique When Performed) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 22612 | Arthrodesis Posterior Or Posterolateral Technique Single Interspace; Lumbar (With Lateral Transverse Technique When Performed) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 22614 | Arthrodesis Posterior Or Posterolateral Technique Single Interspace; 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. | _ | _ | _ |

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| 22630 | Arthrodesis Posterior Interbody Technique Including Laminectomy And/Or 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. | _ | _ | _ |
| 22632 | Arthrodesis Posterior Interbody Technique Including Laminectomy And/Or Discectomy To Prepare Interspace (Other Than For Decompression) Single Interspace Lumbar; 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. | _ | _ | _ |
| 22633 | Arthrodesis Combined Posterior Or Posterolateral Technique With Posterior Interbody Technique Including Laminectomy And/Or Discectomy Sufficient 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. | _ | _ | _ |
| 22634 | Arthrodesis Combined Posterior Or Posterolateral Technique With Posterior Interbody Technique Including Laminectomy And/Or Discectomy Sufficient To Prepare Interspace (Other Than For Decompression) Single Interspace Lumbar; 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. | _ | _ | _ |
| 22800 | Arthrodesis Posterior For Spinal Deformity With Or Without Cast; Up To 6 Vertebral Segments | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 22802 | Arthrodesis Posterior For Spinal Deformity With Or Without Cast; 7 To 12 Vertebral Segments | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 22804 | Arthrodesis Posterior For Spinal Deformity With Or Without Cast; 13 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. | _ | _ | _ |
| 22808 | Arthrodesis Anterior For Spinal Deformity With Or Without Cast; 2 To 3 Vertebral Segments | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 22810 | Arthrodesis Anterior For Spinal Deformity With Or Without Cast; 4 To 7 Vertebral Segments | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 22812 | Arthrodesis Anterior For Spinal Deformity With Or Without Cast; 8 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. | _ | _ | _ |
| 22818 | Kyphectomy Circumferential Exposure Of Spine And Resection Of Vertebral Segment(S) (Including Body And Posterior Elements); Single Or 2 Segments | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 22819 | Kyphectomy Circumferential Exposure Of Spine And Resection Of Vertebral Segment(S) (Including Body And Posterior Elements); 3 Or More Segments | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 22830 | Exploration Of Spinal Fusion | 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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| 22836 | Anterior Thoracic Vertebral Body Tethering Including Thoracoscopy When Performed; Up To 7 Vertebral Segments | EIU: Procedure/service not 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 |
| 22836 | Anterior Thoracic Vertebral Body Tethering Including Thoracoscopy When Performed; Up To 7 Vertebral Segments | 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<br>Retire effective 05/14/2024 |
| 22837 | Anterior Thoracic Vertebral Body Tethering Including Thoracoscopy When Performed; 8 Or More Vertebral Segments | EIU: Procedure/service not 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 |
| 22837 | Anterior Thoracic Vertebral Body Tethering Including Thoracoscopy When Performed; 8 Or More Vertebral Segments | 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<br>Retire effective 05/14/2024 |
| 22838 | Revision (Eg Augmentation Division Of Tether) Replacement Or Removal Of Thoracic Vertebral Body Tethering Including Thoracoscopy 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 |
| 22838 | Revision (Eg Augmentation Division Of Tether) Replacement Or Removal Of Thoracic Vertebral Body Tethering Including Thoracoscopy 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<br>Retire effective 05/14/2024 |
| 22840 | Posterior Non-Segmental Instrumentation (Eg Harrington Rod Technique Pedicle Fixation Across 1 Interspace Atlantoaxial Transarticular Screw Fixation Sublaminar Wiring At C1 Facet Screw Fixation) (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. | _ | _ | _ |
| 22841 | Internal Spinal Fixation By Wiring Of Spinous Processes (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. | _ | _ | _ |
| 22842 | Posterior Segmental Instrumentation (Eg Pedicle Fixation Dual Rods With Multiple Hooks And Sublaminar Wires); 3 To 6 Vertebral Segments (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. | _ | _ | _ |
| 22843 | Posterior Segmental Instrumentation (Eg Pedicle Fixation Dual Rods With Multiple Hooks And Sublaminar Wires); 7 To 12 Vertebral Segments (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. | _ | _ | _ |
| 22844 | Posterior Segmental Instrumentation (Eg Pedicle Fixation Dual Rods With Multiple Hooks And Sublaminar Wires); 13 Or More Vertebral Segments (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. | _ | _ | _ |
| 22845 | Anterior Instrumentation; 2 To 3 Vertebral Segments (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. | _ | _ | _ |
| 22846 | Anterior Instrumentation; 4 To 7 Vertebral Segments (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. | _ | _ | _ |
| 22847 | Anterior Instrumentation; 8 Or More Vertebral Segments (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. | _ | _ | _ |

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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. | _ | _ | _ |

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| 22861 | Revision Including Replacement Of Total Disc Arthroplasty (Artificial Disc) Anterior Approach Single Interspace; Cervical | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 22862 | Revision Including Replacement Of Total Disc Arthroplasty (Artificial Disc) Anterior Approach Single Interspace; Lumbar | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 22864 | Removal Of Total Disc Arthroplasty (Artificial Disc) Anterior Approach Single Interspace; Cervical | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 22865 | Removal Of Total Disc Arthroplasty (Artificial Disc) Anterior Approach Single Interspace; Lumbar | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 22867 | Insertion Of Interlaminar/Interspinous Process Stabilization/Distraction Device Without Fusion Including Image Guidance When Performed With Open Decompression Lumbar; Single Level | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| 22868 | Insertion Of Interlaminar/Interspinous Process Stabilization/Distraction Device Without Fusion Including Image Guidance When Performed With Open Decompression Lumbar; Second Level (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). | _ | _ | _ |
| 22869 | Insertion Of Interlaminar/Interspinous Process Stabilization/Distraction Device Without Open Decompression Or Fusion Including Image Guidance When Performed Lumbar; Single Level | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| 22870 | Insertion Of Interlaminar/Interspinous Process Stabilization/Distraction Device Without Open Decompression Or Fusion Including Image Guidance When Performed Lumbar; Second Level (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). | _ | _ | _ |
| 22899 | Unlisted Procedure Spine | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| 22999 | Unlisted Procedure Abdomen Musculoskeletal System | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| 23105 | Arthrotomy; Glenohumeral Joint With Synovectomy With Or Without Biopsy | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 23107 | Arthrotomy Glenohumeral Joint With Joint Exploration With Or Without Removal Of Loose Or Foreign Body | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 23120 | Claviculectomy; Partial | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 23410 | Repair Of Ruptured Musculotendinous Cuff (Eg Rotator Cuff) Open; Acute | 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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| 23412 | Repair Of Ruptured Musculotendinous Cuff (Eg Rotator Cuff) Open; Chronic | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 23415 | Coracoacromial Ligament Release With Or Without Acromioplasty | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 23420 | Reconstruction Of Complete Shoulder (Rotator) Cuff Avulsion Chronic (Includes Acromioplasty) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 23430 | Tenodesis Of Long Tendon Of Biceps | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 23440 | Resection Or Transplantation Of Long Tendon Of Biceps | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 23450 | Capsulorrhaphy Anterior; Putti-Platt Procedure Or Magnuson Type Operation | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 23455 | Capsulorrhaphy Anterior; With Labral Repair (Eg Bankart Procedure) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 23460 | Capsulorrhaphy Anterior Any Type; With Bone Block | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 23462 | Capsulorrhaphy Anterior Any Type; With Coracoid Process Transfer | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 23465 | Capsulorrhaphy Glenohumeral Joint Posterior With Or Without Bone Block | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 23466 | Capsulorrhaphy Glenohumeral Joint Any Type Multidirectional Instability | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 23470 | Arthroplasty Glenohumeral Joint; Hemiarthroplasty | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 23472 | Arthroplasty Glenohumeral Joint; Total Shoulder (Glenoid And Proximal Humeral Replacement (Eg Total Shoulder)) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 23473 | Revision Of Total Shoulder Arthroplasty Including Allograft When Performed; Humeral Or Glenoid Component | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 23474 | Revision Of Total Shoulder Arthroplasty Including Allograft When Performed; Humeral And Glenoid Component | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 23700 | Manipulation Under Anesthesia Shoulder Joint Including Application Of Fixation Apparatus (Dislocation Excluded) | 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 |

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| 23929 | Unlisted Procedure Shoulder | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.<br>Unlisted or Undefined: Procedures/services not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| 24300 | Manipulation Elbow Under Anesthesia | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 24999 | Unlisted Procedure Humerus Or Elbow | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| 25259 | Manipulation Wrist Under Anesthesia | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 25999 | Unlisted Procedure Forearm Or Wrist | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| 26340 | Manipulation Finger Joint Under Anesthesia Each Joint | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 26341 | Manipulation Palmar Fascial Cord (Ie Dupuytren'S Cord) Post Enzyme Injection (Eg Collagenase) Single Cord | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 26989 | Unlisted Procedure Hands Or Fingers | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| 27096 | Injection Procedure For Sacroiliac Joint Anesthetic/Steroid With Image Guidance (Fluoroscopy Or Ct) Including Arthrography When Performed | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 27120 | Acetabuloplasty; (Eg Whitman Colonna Haygroves Or Cup Type) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 27122 | Acetabuloplasty; Resection Femoral Head (Eg Girdlestone Procedure) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 27125 | Hemiarthroplasty Hip Partial (Eg Femoral Stem Prosthesis Bipolar Arthroplasty) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 27130 | Arthroplasty Acetabular And Proximal Femoral Prosthetic Replacement (Total Hip Arthroplasty) With Or Without Autograft Or Allograft | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 27132 | Conversion Of Previous Hip Surgery To Total Hip Arthroplasty With Or Without Autograft Or Allograft | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 27134 | Revision Of Total Hip Arthroplasty; Both Components With Or Without Autograft Or Allograft | 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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| 27137 | Revision Of Total Hip Arthroplasty; Acetabular Component Only With Or Without Autograft Or Allograft | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 27138 | Revision Of Total Hip Arthroplasty; Femoral Component Only With Or Without Allograft | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 27275 | Manipulation Hip Joint Requiring General Anesthesia | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 27278 | Arthrodesis Sacroiliac Joint Percutaneous With Image Guidance Including Placement Of Intra-Articular Implant(S) (Eg Bone Allograft[S] Synthetic Device[S]) Without Placement Of Transfixation 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). | 5/15/2024 | _ | Add effective 05/15/2024 |
| 27278 | Arthrodesis Sacroiliac Joint Percutaneous With Image Guidance Including Placement Of Intra-Articular Implant(S) (Eg Bone Allograft[S] Synthetic Device[S]) Without Placement Of Transfixation Device | 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<br>Retire effective 05/14/2024 |
| 27279 | Arthrodesis Sacroiliac Joint Percutaneous Or Minimally Invasive (Indirect Visualization) With Image Guidance Includes Obtaining Bone Graft When Performed And Placement Of Transfixing Device | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 27280 | Arthrodesis Sacroiliac Joint Open Includes Obtaining Bone Graft Including Instrumentation When Performed | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 27299 | Unlisted Procedure Pelvis Or Hip Joint | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.<br>Unlisted or Undefined: Procedures/services not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| 27331 | Arthrotomy Knee; Including Joint Exploration Biopsy Or Removal Of Loose Or Foreign Bodies | 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 |
| 27332 | Arthrotomy With Excision Of Semilunar Cartilage (Meniscectomy) Knee; Medial Or Lateral | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 27333 | Arthrotomy With Excision Of Semilunar Cartilage (Meniscectomy) Knee; Medial And Lateral | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 27334 | Arthrotomy With Synovectomy Knee; Anterior Or Posterior | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 27335 | Arthrotomy With Synovectomy Knee; Anterior And Posterior Including Popliteal Area | 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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| 27345 | Excision Of Synovial Cyst Of Popliteal Space (Eg Baker'S Cyst) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 27403 | Arthrotomy With Meniscus Repair Knee | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 27405 | Repair Primary Torn Ligament And/Or Capsule Knee; Collateral | 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 |
| 27407 | Repair Primary Torn Ligament And/Or Capsule Knee; Cruciate | 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 |
| 27409 | Repair Primary Torn Ligament And/Or Capsule Knee; Collateral And Cruciate Ligaments | 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 |
| 27415 | Osteochondral Allograft Knee Open | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 27416 | Osteochondral Autograft(S) Knee Open (Eg Mosaicplasty) (Includes Harvesting Of Autograft[S]) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 27425 | Lateral Retinacular Release Open | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 27427 | Ligamentous Reconstruction (Augmentation) Knee; Extra-Articular | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 27428 | Ligamentous Reconstruction (Augmentation) Knee; Intra-Articular (Open) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 27429 | Ligamentous Reconstruction (Augmentation) Knee; Intra-Articular (Open) And Extra-Articular | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 27437 | Arthroplasty Patella; Without Prosthesis | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 27438 | Arthroplasty Patella; With Prosthesis | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 27440 | Arthroplasty Knee Tibial Plateau; | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 27441 | Arthroplasty Knee Tibial Plateau; With Debridement And Partial Synovectomy | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 27442 | Arthroplasty Femoral Condyles Or Tibial Plateau(S) Knee; | 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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| 27443 | Arthroplasty Femoral Condyles Or Tibial Plateau(S) Knee; With Debridement And Partial Synovectomy | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 27445 | Arthroplasty Knee Hinge Prosthesis (Eg Walldius Type) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 27446 | Arthroplasty Knee Condyle And Plateau; Medial Or Lateral Compartment | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 27447 | Arthroplasty Knee Condyle And Plateau; Medial And Lateral Compartments With Or Without Patella Resurfacing (Total Knee Arthroplasty) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 27486 | Revision Of Total Knee Arthroplasty With Or Without Allograft; 1 Component | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 27487 | Revision Of Total Knee Arthroplasty With Or Without Allograft; Femoral And Entire Tibial Component | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 27488 | Removal Of Prosthesis Including Total Knee Prosthesis Methylmethacrylate With Or Without Insertion Of Spacer Knee | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 27599 | Unlisted Procedure Femur Or Knee | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| 27703 | Arthroplasty Ankle; Revision Total Ankle | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 27860 | Manipulation Of Ankle Under General Anesthesia (Includes Application Of Traction Or Other Fixation Apparatus) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 27899 | Unlisted Procedure Leg Or Ankle | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| 28446 | Open Osteochondral Autograft Talus (Includes Obtaining Graft[S]) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 28890 | Extracorporeal Shock Wave High Energy Performed By A Physician Or Other Qualified Health Care Professional Requiring Anesthesia Other Than Local Including Ultrasound Guidance Involving The Plantar Fascia | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| 28899 | Unlisted Procedure Foot Or Toes | Unlisted: Procedure/service not specifically defined or 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. | _ | _ | _ |
| 29805 | Arthroscopy Shoulder Diagnostic With Or Without Synovial Biopsy (Separate Procedure) | 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 |

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| 29806 | Arthroscopy Shoulder Surgical; Capsulorrhaphy | 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 |
| 29807 | Arthroscopy Shoulder Surgical; Repair Of Slap Lesion | 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 |
| 29819 | Arthroscopy Shoulder Surgical; With Removal Of Loose Body Or Foreign Body | 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 |
| 29820 | Arthroscopy Shoulder Surgical; Synovectomy Partial | 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 |
| 29821 | Arthroscopy Shoulder Surgical; Synovectomy Complete | 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 |
| 29822 | Arthroscopy Shoulder Surgical; Debridement Limited 1 Or 2 Discrete Structures (Eg Humeral Bone Humeral Articular Cartilage Glenoid Bone Glenoid Articular Cartilage Biceps Tendon Biceps Anchor Complex Labrum Articular Capsule Articular Side Of The Rotator Cuff Bursal Side Of The Rotator Cuff Subacromial Bursa Foreign Body[Ies]) | 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 |
| 29823 | Arthroscopy Shoulder Surgical; Debridement Extensive 3 Or More Discrete Structures (Eg Humeral Bone Humeral Articular Cartilage Glenoid Bone Glenoid Articular Cartilage Biceps Tendon Biceps Anchor Complex Labrum Articular Capsule Articular Side Of The Rotator Cuff Bursal Side Of The Rotator Cuff Subacromial Bursa Foreign Body[Ies]) | 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 |
| 29824 | Arthroscopy Shoulder Surgical; Distal Claviculectomy Including Distal Articular Surface (Mumford Procedure) | 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 |
| 29825 | Arthroscopy Shoulder Surgical; With Lysis And Resection Of Adhesions With Or Without Manipulation | 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 |
| 29826 | Arthroscopy Shoulder Surgical; Decompression Of Subacromial Space With Partial Acromioplasty With Coracoacromial Ligament (Ie Arch) Release When Performed (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. | 1/1/2024 | _ | Moved from PA to Recommended Clinical Review 01/01/2024 |
| 29827 | Arthroscopy Shoulder Surgical; With Rotator Cuff Repair | 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 |
| 29828 | Arthroscopy Shoulder Surgical; Biceps Tenodesis | 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 |

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

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| 29877 | Arthroscopy Knee Surgical; Debridement/Shaving Of Articular Cartilage (Chondroplasty) | 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 |
| 29879 | Arthroscopy Knee Surgical; Abrasion Arthroplasty (Includes Chondroplasty Where Necessary) Or Multiple Drilling Or Microfracture | 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 |
| 29880 | Arthroscopy Knee Surgical; With Meniscectomy (Medial And Lateral Including Any Meniscal Shaving) Including Debridement/Shaving Of Articular Cartilage (Chondroplasty) Same Or Separate Compartment(S) When Performed | 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 |
| 29881 | Arthroscopy Knee Surgical; With Meniscectomy (Medial Or Lateral Including Any Meniscal Shaving) Including Debridement/Shaving Of Articular Cartilage (Chondroplasty) Same Or Separate Compartment(S) When Performed | 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 |
| 29882 | Arthroscopy Knee Surgical; With Meniscus Repair (Medial Or Lateral) | 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 |
| 29883 | Arthroscopy Knee Surgical; With Meniscus Repair (Medial And Lateral) | 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 |
| 29884 | Arthroscopy Knee Surgical; With Lysis Of Adhesions With Or Without Manipulation (Separate Procedure) | 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 |
| 29885 | Arthroscopy Knee Surgical; Drilling For Osteochondritis Dissecans With Bone Grafting With Or Without Internal Fixation (Including Debridement Of Base Of Lesion) | 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 |
| 29886 | Arthroscopy Knee Surgical; Drilling For Intact Osteochondritis Dissecans Lesion | 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 |
| 29887 | Arthroscopy Knee Surgical; Drilling For Intact Osteochondritis Dissecans Lesion With Internal Fixation | 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 |
| 29888 | Arthroscopically Aided Anterior Cruciate Ligament Repair/Augmentation Or Reconstruction | 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 |
| 29889 | Arthroscopically Aided Posterior Cruciate Ligament Repair/Augmentation Or Reconstruction | 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 |
| 29892 | Arthroscopically Aided Repair Of Large Osteochondritis Dissecans Lesion Talar Dome Fracture Or Tibial Plafond Fracture With Or Without Internal Fixation (Includes Arthroscopy) | 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 |

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| 29914 | Arthroscopy Hip Surgical; With Femoroplasty (Ie Treatment Of Cam 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 |
| 29914 | Arthroscopy Hip Surgical; With Femoroplasty (Ie 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 (Ie 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.<br>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 | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 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. | _ | _ | _ |

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

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| 31643 | Bronchoscopy Rigid Or Flexible Including Fluoroscopic Guidance When Performed; With Placement Of Catheter(S) For Intracavitary Radioelement Application | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 31899 | Unlisted Procedure Trachea Bronchi | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| 32701 | Thoracic Target(S) Delineation For Stereotactic Body Radiation Therapy (Srs/Sbrt) (Photon Or Particle Beam) Entire Course Of Treatment | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 32851 | Lung Transplant Single; Without Cardiopulmonary Bypass | 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 |
| 32852 | Lung Transplant Single; With Cardiopulmonary Bypass | 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 |
| 32853 | Lung Transplant Double (Bilateral Sequential Or En Bloc); Without Cardiopulmonary Bypass | 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 |
| 32854 | Lung Transplant Double (Bilateral Sequential Or En Bloc); With Cardiopulmonary Bypass | 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 |
| 32994 | Ablation Therapy For Reduction Or Eradication Of 1 Or More Pulmonary Tumor(S) Including Pleura Or Chest Wall When Involved By Tumor Extension Percutaneous Including Imaging Guidance When Performed Unilateral; Cryoablation | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 32998 | Ablation Therapy For Reduction Or Eradication Of 1 Or More Pulmonary Tumor(S) Including Pleura Or Chest Wall When Involved By Tumor Extension Percutaneous Including Imaging Guidance When Performed Unilateral; Radiofrequency | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 32999 | Unlisted Procedure Lungs And Pleura | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| 33211 | Insertion Or Replacement Of Temporary Transvenous Dual Chamber Pacing Electrodes (Separate Procedure) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 33267 | Exclusion Of Left Atrial Appendage Open Any Method (Eg Excision Isolation Via Stapling Oversewing Ligation Plication Clip) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 33268 | Exclusion Of Left Atrial Appendage Open Performed At The Time Of Other Sternotomy Or Thoracotomy Procedure(S) Any Method (Eg Excision Isolation Via Stapling Oversewing Ligation Plication Clip) (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. | _ | _ | _ |
| 33269 | Exclusion Of Left Atrial Appendage Thoracoscopic Any Method (Eg Excision Isolation Via Stapling Oversewing Ligation Plication Clip) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |

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| 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<br>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<br>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<br>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<br>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<br>Retire effective 05/14/2024 |
| 33281 | Repositioning Of Phrenic Nerve Stimulator Transvenous 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 |
| 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<br>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<br>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<br>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. | _ | _ | _ |

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| 33935 | Heart-Lung Transplant With Recipient Cardiectomy-Pneumonectomy | 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 |
| 33945 | Heart Transplant With Or Without Recipient Cardiectomy | 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 |
| 33999 | Unlisted Procedure Cardiac Surgery | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.<br>Unlisted or Undefined: Procedures/services not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| 36299 | Unlisted Procedure Vascular Injection | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| 36465 | Injection Of Non-Compounded Foam Sclerosant With Ultrasound Compression Maneuvers To Guide Dispersion Of The Injectate Inclusive Of All Imaging Guidance And Monitoring; Single Incompetent Extremity Truncal Vein (Eg Great Saphenous Vein Accessory Saphenous Vein) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 36466 | Injection Of Non-Compounded Foam Sclerosant With Ultrasound Compression Maneuvers To Guide Dispersion Of The Injectate Inclusive Of All Imaging Guidance And Monitoring; Multiple Incompetent Truncal Veins (Eg Great Saphenous Vein Accessory Saphenous Vein) Same Leg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 36468 | Injection(S) Of Sclerosant For Spider Veins (Telangiectasia) Limb Or Trunk | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 36470 | Injection Of Sclerosant; Single Incompetent Vein (Other Than Telangiectasia) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 36471 | Injection Of Sclerosant; Multiple Incompetent Veins (Other Than Telangiectasia) Same Leg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 36473 | Endovenous Ablation Therapy Of Incompetent Vein Extremity Inclusive Of All Imaging Guidance And Monitoring Percutaneous Mechanochemical; First Vein Treated | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| 36474 | Endovenous Ablation Therapy Of Incompetent Vein Extremity Inclusive Of All Imaging Guidance And Monitoring Percutaneous Mechanochemical; Subsequent Vein(S) Treated In A Single Extremity Each Through Separate Access Sites (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). | _ | _ | _ |

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| 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) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 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 Code For Primary Procedure) | 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 | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |

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

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

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| 38204 | Management Of Recipient Hematopoietic Progenitor Cell Donor Search And Cell Acquisition | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 38205 | Blood-Derived Hematopoietic Progenitor Cell Harvesting For Transplantation Per Collection; Allogeneic | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 38206 | Blood-Derived Hematopoietic Progenitor Cell Harvesting For Transplantation Per Collection; Autologous | 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. | _ | _ | _ |
| 38207 | Transplant Preparation Of Hematopoietic Progenitor Cells; Cryopreservation And Storage | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 38208 | Transplant Preparation Of Hematopoietic Progenitor Cells; Thawing Of Previously Frozen Harvest Without Washing Per Donor | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 38209 | Transplant Preparation Of Hematopoietic Progenitor Cells; Thawing Of Previously Frozen Harvest With Washing Per Donor | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 38210 | Transplant Preparation Of Hematopoietic Progenitor Cells; Specific Cell Depletion Within Harvest T-Cell Depletion | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 38211 | Transplant Preparation Of Hematopoietic Progenitor Cells; Tumor Cell Depletion | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 38212 | Transplant Preparation Of Hematopoietic Progenitor Cells; Red Blood Cell Removal | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 38213 | Transplant Preparation Of Hematopoietic Progenitor Cells; Platelet Depletion | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 38214 | Transplant Preparation Of Hematopoietic Progenitor Cells; Plasma (Volume) Depletion | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 38215 | Transplant Preparation Of Hematopoietic Progenitor Cells; Cell Concentration In Plasma Mononuclear Or Buffy Coat Layer | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 38230 | Bone Marrow Harvesting For Transplantation; Allogeneic | 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. | _ | _ | _ |
| 38232 | Bone Marrow Harvesting For Transplantation; Autologous | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 38240 | Hematopoietic Progenitor Cell (Hpc); Allogeneic Transplantation Per Donor | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |

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| 38241 | Hematopoietic Progenitor Cell (Hpc); Autologous Transplantation | 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. | _ | _ | _ |
| 38242 | Allogeneic Lymphocyte Infusions | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 38243 | Hematopoietic Progenitor Cell (Hpc); Hpc Boost | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 38308 | Lymphangiotomy Or Other Operations On Lymphatic Channels | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 38589 | Unlisted Laparoscopy Procedure Lymphatic System | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| 38999 | Unlisted Procedure Hemic Or Lymphatic System | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| 39499 | Unlisted Procedure Mediastinum | Unlisted: Procedure/service not specifically defined or 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 classified, maybe subject to contract/clinical review. | _ | _ | _ |
| 40899 | Unlisted Procedure Vestibule Of Mouth | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| 41019 | Placement Of Needles Catheters Or Other Device(S) Into The Head And/Or Neck Region (Percutaneous Transoral Or Transnasal) For Subsequent Interstitial Radioelement Application | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 41530 | Submucosal Ablation Of The Tongue Base Radiofrequency 1 Or More Sites Per Session | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | 3/31/2024 | Retire effective 03/31/2024 |
| 41530 | Submucosal Ablation Of The Tongue Base Radiofrequency 1 Or More Sites Per Session | 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 |
| 41599 | Unlisted Procedure Tongue Floor Of Mouth | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| 41820 | Gingivectomy Excision Gingiva Each Quadrant | Non Covered: Procedure/service not covered by the Plan. 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. Not subject to pre-service review. | _ | _ | _ |
| 41823 | Excision Of Osseous Tuberosities Dentoalveolar Structures | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| 41828 | Excision Of Hyperplastic Alveolar Mucosa Each Quadrant (Specify) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |

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

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| 43499 | Unlisted Procedure Esophagus | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| 43632 | Gastrectomy Partial Distal; With Gastrojejunostomy | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 43633 | Gastrectomy Partial Distal; With Roux-En-Y Reconstruction | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 43644 | Laparoscopy Surgical Gastric Restrictive Procedure; With Gastric Bypass And Roux-En-Y Gastroenterostomy (Roux Limb 150 Cm Or Less) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 43645 | Laparoscopy Surgical Gastric Restrictive Procedure; With Gastric Bypass And Small Intestine Reconstruction To Limit Absorption | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 43647 | Laparoscopy Surgical; Implantation Or Replacement Of Gastric Neurostimulator Electrodes Antrum | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 43648 | Laparoscopy Surgical; Revision Or Removal Of Gastric Neurostimulator Electrodes Antrum | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 43659 | Unlisted Laparoscopy Procedure Stomach | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| 43770 | Laparoscopy Surgical Gastric Restrictive Procedure; Placement Of Adjustable Gastric Restrictive Device (Eg Gastric Band And Subcutaneous Port Components) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 43771 | Laparoscopy Surgical Gastric Restrictive Procedure; Revision Of Adjustable Gastric Restrictive Device Component Only | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 43772 | Laparoscopy Surgical Gastric Restrictive Procedure; Removal Of Adjustable Gastric Restrictive Device Component Only | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 43773 | Laparoscopy Surgical Gastric Restrictive Procedure; Removal And Replacement Of Adjustable Gastric Restrictive Device Component Only | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 43774 | Laparoscopy Surgical Gastric Restrictive Procedure; Removal Of Adjustable Gastric Restrictive Device And Subcutaneous Port Components | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 43775 | Laparoscopy Surgical Gastric Restrictive Procedure; Longitudinal Gastrectomy (Ie Sleeve Gastrectomy) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 43842 | Gastric Restrictive Procedure Without Gastric Bypass For Morbid Obesity; Vertical-Banded Gastroplasty | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to 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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| 43845 | Gastric Restrictive Procedure With Partial Gastrectomy Pylorus-Preserving Duodenoileostomy And Ileoileostomy (50 To 100 Cm Common Channel) To Limit Absorption (Biliopancreatic Diversion With Duodenal Switch) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 43846 | Gastric Restrictive Procedure With Gastric Bypass For Morbid Obesity; With Short Limb (150 Cm Or Less) Roux-En-Y Gastroenterostomy | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 43847 | Gastric Restrictive Procedure With Gastric Bypass For Morbid Obesity; With Small Intestine Reconstruction To Limit Absorption | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 43848 | Revision Open Of Gastric Restrictive Procedure For Morbid Obesity Other Than Adjustable Gastric Restrictive Device (Separate Procedure) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 43881 | Implantation Or Replacement Of Gastric Neurostimulator Electrodes Antrum Open | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 43886 | Gastric Restrictive Procedure Open; Revision Of Subcutaneous Port Component Only | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 43887 | Gastric Restrictive Procedure Open; Removal Of Subcutaneous Port Component Only | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 43888 | Gastric Restrictive Procedure Open; Removal And Replacement Of Subcutaneous Port Component Only | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 43999 | Unlisted Procedure Stomach | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| 44135 | Intestinal Allotransplantation; From Cadaver Donor | 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 |
| 44136 | Intestinal Allotransplantation; From Living Donor | 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 |
| 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 classified, maybe subject to contract/clinical review. | _ | _ | _ |
| 44899 | Unlisted Procedure Meckel'S Diverticulum And The Mesentery | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| 44979 | Unlisted Laparoscopy Procedure Appendix | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| 45399 | Unlisted Procedure Colon | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| 45499 | Unlisted Laparoscopy Procedure Rectum | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| 45999 | Unlisted Procedure Rectum | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |

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

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| 50365 | Renal Allotransplantation Implantation Of Graft; With Recipient Nephrectomy | 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 |
| 50380 | Renal autotransplantation, reimplantation of kidney | 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 |
| 50549 | Unlisted Laparoscopy Procedure Renal | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| 50592 | Ablation 1 Or More Renal Tumor(S) Percutaneous Unilateral Radiofrequency | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 50593 | Ablation Renal Tumor(S) Unilateral Percutaneous Cryotherapy | MP Criteria: Procedure/service reviewed against Medical 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. | _ | _ | _ |
| 51715 | Endoscopic Injection Of Implant Material Into The Submucosal Tissues Of The Urethra And/Or Bladder Neck | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 51999 | Unlisted Laparoscopy Procedure Bladder | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| 52284 | Cystourethroscopy With Mechanical Urethral Dilation And Urethral Therapeutic Drug Delivery By Drug-Coated Balloon Catheter For Urethral Stricture Or Stenosis Male Including Fluoroscopy 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 |
| 52284 | Cystourethroscopy With Mechanical Urethral Dilation And Urethral Therapeutic Drug Delivery By Drug-Coated Balloon Catheter For Urethral Stricture Or Stenosis Male Including Fluoroscopy 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<br>Retire effective 05/14/2024 |
| 52327 | Cystourethroscopy (Including Ureteral Catheterization); With Subureteric Injection Of Implant Material | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 52441 | Cystourethroscopy With Insertion Of Permanent Adjustable Transprostatic Implant; Single Implant | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 52442 | Cystourethroscopy With Insertion Of Permanent Adjustable Transprostatic Implant; Each Additional Permanent Adjustable Transprostatic Implant (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. | _ | _ | _ |
| 53855 | Insertion Of A Temporary Prostatic Urethral Stent Including Urethral Measurement | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | 5/14/2024 | Retire effective 05/14/2024 |
| 53855 | Insertion Of A Temporary Prostatic Urethral Stent Including Urethral Measurement | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | 5/14/2024 | Retire effective 05/14/2024 |

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| 53855 | Insertion Of A Temporary Prostatic Urethral Stent Including Urethral Measurement | EIU: Procedure/service not 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 |
| 53860 | Transurethral Radiofrequency Micro-Remodeling Of The Female Bladder Neck And Proximal Urethra For Stress Urinary Incontinence | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| 53899 | Unlisted Procedure Urinary System | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| 54125 | Amputation Of Penis; Complete | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 54200 | Injection Procedure For Peyronie Disease; | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 54205 | Injection Procedure For Peyronie Disease; With Surgical Exposure Of Plaque | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 54235 | Injection Of Corpora Cavernosa With Pharmacologic Agent(S) (Eg Papaverine Phentolamine) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 54400 | Insertion Of Penile Prosthesis; Non-Inflatable (Semi-Rigid) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 54401 | Insertion Of Penile Prosthesis; Inflatable (Self-Contained) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 54405 | Insertion Of Multi-Component Inflatable Penile Prosthesis Including Placement Of Pump Cylinders And Reservoir | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 54660 | Insertion Of Testicular Prosthesis (Separate Procedure) | MP Criteria: Procedure/service reviewed against Medical 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. | _ | _ | _ |
| 55860 | Exposure Of Prostate Any Approach For Insertion Of Radioactive Substance; | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 55862 | Exposure Of Prostate Any Approach For Insertion Of Radioactive Substance; With Lymph Node Biopsy(S) (Limited Pelvic Lymphadenectomy) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 55865 | Exposure Of Prostate Any Approach For Insertion Of Radioactive Substance; With Bilateral Pelvic Lymphadenectomy Including External Iliac Hypogastric And Obturator Nodes | 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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| 55874 | Transperineal Placement Of Biodegradable Material Peri-Prostatic Single Or Multiple Injection(S) Including Image Guidance When Performed | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 55875 | Transperineal Placement Of Needles Or Catheters Into Prostate For Interstitial Radioelement Application With Or Without Cystoscopy | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 55880 | Ablation Of Malignant Prostate Tissue Transrectal With High Intensity-Focused Ultrasound (Hifu) Including Ultrasound Guidance | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 55899 | Unlisted Procedure Male Genital System | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.<br>Unlisted or Undefined: Procedures/services not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| 55920 | Placement Of Needles Or Catheters Into Pelvic Organs And/Or Genitalia (Except Prostate) For Subsequent Interstitial Radioelement Application | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 55970 | Intersex Surgery; Male To Female | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 55980 | Intersex Surgery; Female To Male | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 56805 | Clitoroplasty For Intersex State | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 56810 | Perineoplasty Repair Of Perineum Nonobstetrical (Separate Procedure) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 57155 | Insertion Of Uterine Tandem And/Or Vaginal Ovoids For Clinical Brachytherapy | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 57156 | Insertion Of A Vaginal Radiation Afterloading Apparatus For Clinical Brachytherapy | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 57291 | Construction Of Artificial Vagina; Without Graft | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 57292 | Construction Of Artificial Vagina; With Graft | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 57335 | Vaginoplasty For Intersex State | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |

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

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| 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) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/15/2024 | 6/30/2024 | Add effective 05/15/2024<br>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). | _ | _ | _ |

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| 62264 | 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; 1 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). | _ | _ | _ |
| 62280 | Injection/Infusion Of Neurolytic Substance (Eg Alcohol Phenol Iced Saline Solutions) With Or Without Other Therapeutic Substance; Subarachnoid | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 62281 | Injection/Infusion Of Neurolytic Substance (Eg Alcohol Phenol Iced Saline Solutions) With Or Without Other Therapeutic Substance; Epidural Cervical Or Thoracic | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 62282 | Injection/Infusion Of Neurolytic Substance (Eg Alcohol Phenol Iced Saline Solutions) With Or Without Other Therapeutic Substance; Epidural Lumbar Sacral (Caudal) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 62287 | Decompression Procedure Percutaneous Of Nucleus Pulposus Of Intervertebral Disc Any Method Utilizing Needle Based Technique To Remove Disc Material Under Fluoroscopic Imaging Or Other Form Of Indirect Visualization With Discography And/Or Epidural Injection(S) At The Treated Level(S) When Performed Single Or Multiple Levels 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). | _ | _ | _ |
| 62292 | Injection Procedure For Chemonucleolysis Including Discography Intervertebral Disc Single Or Multiple Levels Lumbar | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 62320 | 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 Cervical Or Thoracic; Without Imaging Guidance | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 62321 | 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 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. | _ | _ | _ |
| 62322 | 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); Without Imaging Guidance | 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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| 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. | _ | _ | _ |

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| 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. | _ | _ | _ |

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| 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. | _ | _ | _ |

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| 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. | _ | _ | _ |

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| 63086 | Vertebral Corpectomy (Vertebral Body Resection) Partial Or Complete Transthoracic Approach With Decompression Of Spinal Cord And/Or Nerve Root(S); Thoracic 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. | _ | _ | _ |
| 63087 | Vertebral Corpectomy (Vertebral Body Resection) Partial Or Complete Combined Thoracolumbar Approach With Decompression Of Spinal Cord Cauda Equina Or Nerve Root(S) Lower Thoracic Or Lumbar; Single Segment | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 63088 | Vertebral Corpectomy (Vertebral Body Resection) Partial Or Complete Combined Thoracolumbar Approach With Decompression Of Spinal Cord Cauda Equina Or Nerve Root(S) Lower Thoracic Or Lumbar; 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. | _ | _ | _ |
| 63090 | Vertebral Corpectomy (Vertebral Body Resection) Partial Or Complete Transperitoneal Or Retroperitoneal Approach With Decompression Of Spinal Cord Cauda Equina Or Nerve Root(S) Lower Thoracic Lumbar Or Sacral; Single Segment | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 63091 | Vertebral Corpectomy (Vertebral Body Resection) Partial Or Complete Transperitoneal Or Retroperitoneal Approach 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) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 63101 | Vertebral Corpectomy (Vertebral Body Resection) Partial Or Complete Lateral Extracavitary Approach With Decompression Of Spinal Cord And/Or Nerve Root(S) (Eg For Tumor Or Retropulsed Bone Fragments); Thoracic Single Segment | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 63102 | Vertebral Corpectomy (Vertebral Body Resection) Partial Or Complete Lateral Extracavitary Approach With Decompression Of Spinal Cord And/Or Nerve Root(S) (Eg For Tumor Or Retropulsed Bone Fragments); Lumbar Single Segment | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 63103 | Vertebral Corpectomy (Vertebral Body Resection) Partial Or Complete Lateral Extracavitary Approach With Decompression Of Spinal Cord And/Or Nerve Root(S) (Eg For Tumor Or Retropulsed Bone Fragments); Thoracic Or Lumbar 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. | _ | _ | _ |
| 63185 | Laminectomy With Rhizotomy; 1 Or 2 Segments | 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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| 63190 | Laminectomy With Rhizotomy; More Than 2 Segments | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 63191 | Laminectomy With Section Of Spinal Accessory Nerve | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 63200 | Laminectomy With Release Of Tethered Spinal Cord Lumbar | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 63250 | Laminectomy For Excision Or Occlusion Of Arteriovenous Malformation Of Spinal Cord; Cervical | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 63252 | Laminectomy For Excision Or Occlusion Of Arteriovenous Malformation Of Spinal Cord; Thoracolumbar | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 63265 | Laminectomy For Excision Or Evacuation Of Intraspinal Lesion Other Than Neoplasm Extradural; Cervical | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 63267 | Laminectomy For Excision Or Evacuation Of Intraspinal Lesion Other Than Neoplasm Extradural; Lumbar | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 63270 | Laminectomy For Excision Of Intraspinal Lesion Other Than Neoplasm Intradural; Cervical | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 63272 | Laminectomy For Excision Of Intraspinal Lesion Other Than Neoplasm Intradural; Lumbar | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 63275 | Laminectomy For Biopsy/Excision Of Intraspinal Neoplasm; Extradural Cervical | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 63277 | Laminectomy For Biopsy/Excision Of Intraspinal Neoplasm; Extradural Lumbar | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 63280 | Laminectomy For Biopsy/Excision Of Intraspinal Neoplasm; Intradural Extramedullary Cervical | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 63282 | Laminectomy For Biopsy/Excision Of Intraspinal Neoplasm; Intradural Extramedullary Lumbar | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 63285 | Laminectomy For Biopsy/Excision Of Intraspinal Neoplasm; Intradural Intramedullary Cervical | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 63287 | Laminectomy For Biopsy/Excision Of Intraspinal Neoplasm; Intradural Intramedullary Thoracolumbar | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 63290 | Laminectomy For Biopsy/Excision Of Intraspinal Neoplasm; Combined Extradural-Intradural Lesion Any Level | 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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| 63300 | Vertebral Corpectomy (Vertebral Body Resection) Partial Or Complete For Excision Of Intraspinal Lesion Single Segment; Extradural Cervical | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 63301 | Vertebral Corpectomy (Vertebral Body Resection) Partial Or Complete For Excision Of Intraspinal Lesion Single Segment; Extradural Thoracic By Transthoracic Approach | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 63302 | Vertebral Corpectomy (Vertebral Body Resection) Partial Or Complete For Excision Of Intraspinal Lesion Single Segment; Extradural Thoracic By Thoracolumbar Approach | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 63303 | Vertebral Corpectomy (Vertebral Body Resection) Partial Or Complete For Excision Of Intraspinal Lesion Single Segment; Extradural Lumbar Or Sacral By Transperitoneal Or Retroperitoneal Approach | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 63304 | Vertebral Corpectomy (Vertebral Body Resection) Partial Or Complete For Excision Of Intraspinal Lesion Single Segment; Intradural Cervical | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 63305 | Vertebral Corpectomy (Vertebral Body Resection) Partial Or Complete For Excision Of Intraspinal Lesion Single Segment; Intradural Thoracic By Transthoracic Approach | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 63306 | Vertebral Corpectomy (Vertebral Body Resection) Partial Or Complete For Excision Of Intraspinal Lesion Single Segment; Intradural Thoracic By Thoracolumbar Approach | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 63307 | Vertebral Corpectomy (Vertebral Body Resection) Partial Or Complete For Excision Of Intraspinal Lesion Single Segment; Intradural Lumbar Or Sacral By Transperitoneal Or Retroperitoneal Approach | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 63308 | Vertebral Corpectomy (Vertebral Body Resection) Partial Or Complete For Excision Of Intraspinal Lesion Single Segment; Each Additional Segment (List Separately In Addition To Codes For Single Segment) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 63620 | Stereotactic Radiosurgery (Particle Beam Gamma Ray Or Linear Accelerator); 1 Spinal Lesion | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 63621 | Stereotactic Radiosurgery (Particle Beam Gamma Ray Or Linear Accelerator); Each Additional Spinal Lesion (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. | _ | _ | _ |
| 63650 | Percutaneous Implantation Of Neurostimulator Electrode Array Epidural | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 63655 | Laminectomy For Implantation Of Neurostimulator Electrodes Plate/Paddle Epidural | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 63663 | Revision Including Replacement When Performed Of Spinal Neurostimulator Electrode Percutaneous Array(S) Including Fluoroscopy When Performed | 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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| 63664 | Revision Including Replacement When Performed Of Spinal Neurostimulator Electrode Plate/Paddle(S) Placed Via Laminotomy Or Laminectomy Including Fluoroscopy When Performed | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 63685 | Insertion Or Replacement Of Spinal Neurostimulator Pulse Generator Or Receiver Requiring Pocket Creation And Connection Between Electrode Array And Pulse Generator Or Receiver | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 63688 | Revision Or Removal Of Implanted Spinal Neurostimulator Pulse Generator Or Receiver With Detachable Connection To Electrode Array | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 64451 | Injection(S) Anesthetic Agent(S) And/Or Steroid; Nerves Innervating The Sacroiliac Joint With Image Guidance (Ie Fluoroscopy Or Computed Tomography) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 64479 | Injection(S) Anesthetic Agent(S) And/Or Steroid; Transforaminal Epidural With Imaging Guidance (Fluoroscopy Or Ct) 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. | _ | _ | _ |
| 64480 | Injection(S) Anesthetic Agent(S) And/Or Steroid; Transforaminal Epidural With Imaging Guidance (Fluoroscopy Or Ct) Cervical Or Thoracic Each Additional 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. | _ | _ | _ |
| 64483 | Injection(S) Anesthetic Agent(S) And/Or Steroid; Transforaminal Epidural With Imaging Guidance (Fluoroscopy Or Ct) 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. | _ | _ | _ |
| 64484 | Injection(S) Anesthetic Agent(S) And/Or Steroid; Transforaminal Epidural With Imaging Guidance (Fluoroscopy Or Ct) Lumbar Or Sacral Each Additional 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. | _ | _ | _ |
| 64490 | Injection(S) Diagnostic Or Therapeutic Agent Paravertebral Facet (Zygapophyseal) Joint (Or Nerves Innervating That Joint) With Image Guidance (Fluoroscopy Or Ct) 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. | _ | _ | _ |
| 64491 | Injection(S) Diagnostic Or Therapeutic Agent Paravertebral Facet (Zygapophyseal) Joint (Or Nerves Innervating That Joint) With Image Guidance (Fluoroscopy Or Ct) 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. | _ | _ | _ |
| 64492 | Injection(S) Diagnostic Or Therapeutic Agent Paravertebral Facet (Zygapophyseal) Joint (Or Nerves Innervating That Joint) With Image Guidance (Fluoroscopy Or Ct) 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. | _ | _ | _ |

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| 64493 | Injection(S) Diagnostic Or Therapeutic Agent Paravertebral Facet (Zygapophyseal) Joint (Or Nerves Innervating That Joint) With Image Guidance (Fluoroscopy Or Ct) 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. | _ | _ | _ |
| 64494 | Injection(S) Diagnostic Or Therapeutic Agent Paravertebral Facet (Zygapophyseal) Joint (Or Nerves Innervating That Joint) With Image Guidance (Fluoroscopy Or Ct) 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. | _ | _ | _ |
| 64495 | Injection(S) Diagnostic Or Therapeutic Agent Paravertebral Facet (Zygapophyseal) Joint (Or Nerves Innervating That Joint) With Image Guidance (Fluoroscopy Or Ct) 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. | _ | _ | _ |
| 64510 | Injection Anesthetic Agent; Stellate Ganglion (Cervical Sympathetic) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 64520 | Injection Anesthetic Agent; Lumbar Or Thoracic (Paravertebral Sympathetic) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 64555 | Percutaneous Implantation Of Neurostimulator Electrode Array; Peripheral Nerve (Excludes Sacral Nerve) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 64561 | Percutaneous Implantation Of Neurostimulator Electrode Array; Sacral Nerve (Transforaminal Placement) Including Image Guidance If Performed | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 64566 | Posterior Tibial Neurostimulation Percutaneous Needle Electrode Single Treatment Includes Programming | 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 |
| 64568 | Open Implantation Of Cranial Nerve (Eg Vagus Nerve) Neurostimulator Electrode Array And Pulse Generator | 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 |
| 64575 | Open Implantation Of Neurostimulator Electrode Array; Peripheral Nerve (Excludes Sacral Nerve) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 64581 | Open Implantation Of Neurostimulator Electrode Array; Sacral Nerve (Transforaminal Placement) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 64582 | Open Implantation Of Hypoglossal Nerve Neurostimulator Array Pulse Generator And Distal Respiratory Sensor Electrode Or Electrode Array | 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. | _ | 3/31/2024 | Retire effective 03/31/2024 |
| 64590 | Insertion Or Replacement Of Peripheral Sacral Or Gastric Neurostimulator Pulse Generator Or Receiver Requiring Pocket Creation And Connection Between Electrode Array And Pulse Generator Or Receiver | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |

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| 64596 | Insertion Or Replacement Of Percutaneous Electrode Array Peripheral Nerve With Integrated Neurostimulator Including Imaging Guidance When Performed; Initial Electrode Array | 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 |
| 64597 | Insertion Or Replacement Of Percutaneous Electrode Array Peripheral Nerve With Integrated Neurostimulator Including Imaging Guidance When Performed; Each Additional Electrode Array (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 | _ | Add effective 02/15/2024 |
| 64624 | Destruction By Neurolytic Agent Genicular Nerve Branches Including Imaging Guidance When Performed | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 64625 | Radiofrequency Ablation Nerves Innervating The Sacroiliac Joint With Image Guidance (Ie Fluoroscopy Or Computed Tomography) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 64628 | Thermal Destruction Of Intraosseous Basivertebral Nerve Including All Imaging Guidance; First 2 Vertebral Bodies Lumbar Or Sacral | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| 64629 | Thermal Destruction Of Intraosseous Basivertebral Nerve Including All Imaging Guidance; Each Additional Vertebral Body Lumbar Or Sacral (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). | _ | _ | _ |
| 64633 | Destruction By Neurolytic Agent Paravertebral Facet Joint Nerve(S) With Imaging Guidance (Fluoroscopy Or Ct); Cervical Or Thoracic Single Facet Joint | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 64634 | Destruction By Neurolytic Agent Paravertebral Facet Joint Nerve(S) With Imaging Guidance (Fluoroscopy Or Ct); Cervical Or Thoracic Each Additional Facet Joint (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. | _ | _ | _ |
| 64635 | Destruction By Neurolytic Agent Paravertebral Facet Joint Nerve(S) With Imaging Guidance (Fluoroscopy Or Ct); Lumbar Or Sacral Single Facet Joint | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 64636 | Destruction By Neurolytic Agent Paravertebral Facet Joint Nerve(S) With Imaging Guidance (Fluoroscopy Or Ct); Lumbar Or Sacral Each Additional Facet Joint (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. | _ | _ | _ |
| 64640 | Destruction By Neurolytic Agent; Other Peripheral Nerve Or Branch | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 64716 | Neuroplasty And/Or Transposition; Cranial Nerve (Specify) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 64732 | Transection Or Avulsion Of; Supraorbital Nerve | 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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| 64734 | Transection Or Avulsion Of; Infraorbital Nerve | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 64771 | Transection Or Avulsion Of Other Cranial Nerve Extradural | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 64999 | Unlisted Procedure Nervous System | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | _ | _ | _ |
| 65760 | Keratomileusis | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| 65770 | Keratoprosthesis | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 65785 | Implantation Of Intrastromal Corneal Ring Segments | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 66174 | Transluminal Dilation Of Aqueous Outflow Canal (Eg Canaloplasty); Without Retention Of Device Or Stent | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 66175 | Transluminal Dilation Of Aqueous Outflow Canal (Eg Canaloplasty); With Retention Of Device Or Stent | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 66179 | Aqueous Shunt To Extraocular Equatorial Plate Reservoir External Approach; Without Graft | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 66180 | Aqueous Shunt To Extraocular Equatorial Plate Reservoir External Approach; With Graft | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 66183 | Insertion Of Anterior Segment Aqueous Drainage Device Without Extraocular Reservoir External Approach | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 66989 | 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 (Eg Iris Expansion Device Suture Support For Intraocular Lens Or Primary Posterior Capsulorrhexis) Or Performed On Patients In The Amblyogenic Developmental Stage; With Insertion Of Intraocular (Eg Trabecular Meshwork Supraciliary Suprachoroidal) Anterior Segment Aqueous Drainage Device Without Extraocular Reservoir Internal Approach, One Or More | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |

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| 66991 | Extracapsular Cataract Removal With Insertion Of Intraocular Lens Prosthesis (1 Stage Procedure) Manual Or Mechanical Technique (Eg Irrigation And Aspiration Or Phacoemulsification); With Insertion Of Intraocular (Eg Trabecular Meshwork Supraciliary Suprachoroidal) Anterior Segment Aqueous Drainage Device Without Extraocular Reservoir Internal Approach One Or More | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 66999 | Unlisted Procedure Anterior Segment Of Eye | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| 67027 | Implantation Of Intravitreal Drug Delivery System (Eg Ganciclovir Implant) Includes Concomitant Removal Of Vitreous | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 67218 | Destruction Of Localized Lesion Of Retina (Eg Macular Edema Tumors) 1 Or More Sessions; Radiation By Implantation Of Source (Includes Removal Of Source) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 67299 | Unlisted Procedure Posterior Segment | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| 67399 | Unlisted Procedure Extraocular Muscle | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| 67516 | Suprachoroidal Space Injection Of Pharmacologic Agent (Separate Procedure) | 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 |
| 67599 | Unlisted Procedure Orbit | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| 67900 | Repair Of Brow Ptosis (Supraciliary Mid-Forehead Or Coronal Approach) | 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. | _ | _ | _ |
| 67901 | Repair Of Blepharoptosis; Frontalis Muscle Technique With Suture Or Other Material (Eg Banked Fascia) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 67902 | Repair Of Blepharoptosis; Frontalis Muscle Technique With Autologous Fascial Sling (Includes Obtaining Fascia) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 67903 | Repair Of Blepharoptosis; (Tarso) Levator Resection Or Advancement Internal Approach | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 67904 | Repair Of Blepharoptosis; (Tarso) Levator Resection Or Advancement External Approach | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 67906 | Repair Of Blepharoptosis; Superior Rectus Technique With Fascial Sling (Includes Obtaining Fascia) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 67908 | Repair Of Blepharoptosis; Conjunctivo-Tarso-Muller'S Muscle-Levator Resection (Eg Fasanella-Servat Type) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |

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| 67999 | Unlisted Procedure Eyelids | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| 68399 | Unlisted Procedure Conjunctiva | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| 68899 | Unlisted Procedure Lacrimal System | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| 69090 | Ear Piercing | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 69300 | Otoplasty Protruding Ear With Or Without Size Reduction | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 69399 | Unlisted Procedure External Ear | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| 69705 | Nasopharyngoscopy Surgical With Dilation Of Eustachian Tube (Ie Balloon Dilation); Unilateral | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 69706 | Nasopharyngoscopy Surgical With Dilation Of Eustachian Tube (Ie Balloon Dilation); Bilateral | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 69714 | Implantation Osseointegrated Implant Skull; With Percutaneous Attachment To External Speech Processor | 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. | _ | _ | _ |
| 69716 | Implantation Osseointegrated Implant Skull; With Magnetic Transcutaneous Attachment To External Speech Processor Within The Mastoid And/Or Resulting In Removal Of Less Than 100 Sq Mm Surface Area Of Bone Deep To The Outer Cranial Cortex | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 69717 | Replacement (Including Removal Of Existing Device) Osseointegrated Implant Skull; With Percutaneous Attachment To External Speech Processor | 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. | _ | _ | _ |
| 69719 | Replacement (Including Removal Of Existing Device) Osseointegrated Implant Skull; With Magnetic Transcutaneous Attachment To External Speech Processor Within The Mastoid And/Or Involving A Bony Defect Less Than 100 Sq Mm Surface Area Of Bone Deep To The Outer Cranial Cortex | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 69728 | Removal Entire Osseointegrated Implant Skull; With Magnetic Transcutaneous Attachment To External Speech Processor Outside The Mastoid And Involving A Bony Defect Greater Than Or Equal To 100 Sq Mm Surface Area Of Bone Deep To The Outer Cranial Cortex | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |

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| 69730 | Replacement (Including Removal Of Existing Device) Osseointegrated Implant Skull; With Magnetic Transcutaneous Attachment To External Speech Processor Outside The Mastoid And Involving A Bony Defect Greater Than Or Equal To 100 Sq Mm Surface Area Of Bone Deep To The Outer Cranial Cortex | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 69799 | Unlisted Procedure Middle Ear | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| 69930 | Cochlear Device Implantation With Or Without Mastoidectomy | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | _ | _ | _ |
| 69949 | Unlisted 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 | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| 70450 | Computed Tomography Head Or Brain; Without Contrast Material | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 70460 | Computed Tomography Head Or Brain; 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. | _ | _ | _ |
| 70470 | Computed Tomography Head Or Brain; 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. | _ | _ | _ |
| 70480 | Computed Tomography Orbit Sella Or Posterior Fossa Or Outer Middle Or Inner Ear; Without Contrast Material | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 70481 | Computed Tomography Orbit Sella Or Posterior Fossa Or Outer Middle Or Inner Ear; 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. | _ | _ | _ |
| 70482 | Computed Tomography Orbit Sella Or Posterior Fossa Or Outer Middle Or Inner Ear; 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. | _ | _ | _ |
| 70486 | Computed Tomography Maxillofacial Area; Without Contrast Material | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 70487 | Computed Tomography Maxillofacial Area; 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. | _ | _ | _ |
| 70488 | Computed Tomography Maxillofacial Area; 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. | _ | _ | _ |
| 70490 | Computed Tomography Soft Tissue Neck; Without Contrast Material | 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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| 70491 | Computed Tomography Soft Tissue Neck; 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. | _ | _ | _ |
| 70492 | Computed Tomography Soft Tissue Neck; 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. | _ | _ | _ |
| 70496 | Computed Tomographic Angiography Head 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. | _ | _ | _ |
| 70498 | Computed Tomographic Angiography Neck 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. | _ | _ | _ |
| 70540 | Magnetic Resonance (Eg Proton) Imaging Orbit Face And/Or Neck; 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. | _ | _ | _ |
| 70542 | Magnetic Resonance (Eg Proton) Imaging Orbit Face And/Or Neck; 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. | _ | _ | _ |
| 70543 | Magnetic Resonance (Eg Proton) Imaging Orbit Face And/Or Neck; 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. | _ | _ | _ |
| 70544 | Magnetic Resonance Angiography Head; 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. | _ | _ | _ |
| 70545 | Magnetic Resonance Angiography Head; 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. | _ | _ | _ |
| 70546 | Magnetic Resonance Angiography Head; 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. | _ | _ | _ |
| 70547 | Magnetic Resonance Angiography Neck; 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. | _ | _ | _ |
| 70548 | Magnetic Resonance Angiography Neck; 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. | _ | _ | _ |
| 70549 | Magnetic Resonance Angiography Neck; 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. | _ | _ | _ |
| 70551 | Magnetic Resonance (Eg Proton) Imaging Brain (Including Brain Stem); Without Contrast Material | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 70552 | Magnetic Resonance (Eg Proton) Imaging Brain (Including Brain Stem); 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. | _ | _ | _ |
| 70553 | Magnetic Resonance (Eg Proton) Imaging Brain (Including Brain Stem); Without Contrast Material 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. | _ | _ | _ |

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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. | _ | _ | _ |

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| 72128 | Computed Tomography Thoracic 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. | _ | _ | _ |
| 72129 | Computed Tomography Thoracic 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. | _ | _ | _ |
| 72130 | Computed Tomography Thoracic 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. | _ | _ | _ |
| 72131 | Computed Tomography Lumbar 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. | _ | _ | _ |
| 72132 | Computed Tomography Lumbar 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. | _ | _ | _ |
| 72133 | Computed Tomography Lumbar 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. | _ | _ | _ |
| 72141 | Magnetic Resonance (Eg Proton) Imaging Spinal Canal And Contents Cervical; Without Contrast Material | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 72142 | Magnetic Resonance (Eg Proton) Imaging Spinal Canal And Contents Cervical; 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. | _ | _ | _ |
| 72146 | Magnetic Resonance (Eg Proton) Imaging Spinal Canal And Contents Thoracic; Without Contrast Material | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 72147 | Magnetic Resonance (Eg Proton) Imaging Spinal Canal And Contents Thoracic; 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. | _ | _ | _ |
| 72148 | Magnetic Resonance (Eg Proton) Imaging Spinal Canal And Contents Lumbar; Without Contrast Material | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 72149 | Magnetic Resonance (Eg Proton) Imaging Spinal Canal And Contents Lumbar; 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. | _ | _ | _ |
| 72156 | Magnetic Resonance (Eg Proton) Imaging Spinal Canal And Contents Without Contrast Material Followed By Contrast Material(S) And Further Sequences; Cervical | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 72157 | Magnetic Resonance (Eg Proton) Imaging Spinal Canal And Contents Without Contrast Material Followed By Contrast Material(S) And Further Sequences; Thoracic | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 72158 | Magnetic Resonance (Eg Proton) Imaging Spinal Canal And Contents Without Contrast Material Followed By Contrast Material(S) And Further Sequences; Lumbar | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 72159 | Magnetic Resonance Angiography Spinal Canal And Contents 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. | _ | _ | _ |

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| 72191 | Computed Tomographic Angiography Pelvis 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. | _ | _ | _ |
| 72192 | Computed Tomography Pelvis; Without Contrast Material | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 72193 | Computed Tomography Pelvis; 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. | _ | _ | _ |
| 72194 | Computed Tomography Pelvis; 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. | _ | _ | _ |
| 72195 | Magnetic Resonance (Eg Proton) Imaging Pelvis; 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. | _ | _ | _ |
| 72196 | Magnetic Resonance (Eg Proton) Imaging Pelvis; 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. | _ | _ | _ |
| 72197 | Magnetic Resonance (Eg Proton) Imaging Pelvis; 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. | _ | _ | _ |
| 72198 | Magnetic Resonance Angiography Pelvis 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. | _ | _ | _ |
| 73200 | Computed Tomography Upper Extremity; Without Contrast Material | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 73201 | Computed Tomography Upper Extremity; 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. | _ | _ | _ |
| 73202 | Computed Tomography Upper Extremity; 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. | _ | _ | _ |
| 73206 | Computed Tomographic Angiography Upper Extremity 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. | _ | _ | _ |
| 73218 | Magnetic Resonance (Eg Proton) Imaging Upper Extremity Other Than Joint; 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. | _ | _ | _ |
| 73219 | Magnetic Resonance (Eg Proton) Imaging Upper Extremity Other Than Joint; 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. | _ | _ | _ |
| 73220 | Magnetic Resonance (Eg Proton) Imaging Upper Extremity Other Than Joint; 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. | _ | _ | _ |
| 73221 | Magnetic Resonance (Eg Proton) Imaging Any Joint Of Upper Extremity; 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. | _ | _ | _ |

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| 73222 | Magnetic Resonance (Eg Proton) Imaging Any Joint Of Upper Extremity; 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. | _ | _ | _ |
| 73223 | Magnetic Resonance (Eg Proton) Imaging Any Joint Of Upper Extremity; 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. | _ | _ | _ |
| 73225 | Magnetic Resonance Angiography Upper Extremity 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. | _ | _ | _ |
| 73700 | Computed Tomography Lower Extremity; Without Contrast Material | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 73701 | Computed Tomography Lower Extremity; 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. | _ | _ | _ |
| 73702 | Computed Tomography Lower Extremity; 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. | _ | _ | _ |
| 73706 | Computed Tomographic Angiography Lower Extremity 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. | _ | _ | _ |
| 73718 | Magnetic Resonance (Eg Proton) Imaging Lower Extremity Other Than Joint; 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. | _ | _ | _ |
| 73719 | Magnetic Resonance (Eg Proton) Imaging Lower Extremity Other Than Joint; 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. | _ | _ | _ |
| 73720 | Magnetic Resonance (Eg Proton) Imaging Lower Extremity Other Than Joint; 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. | _ | _ | _ |
| 73721 | Magnetic Resonance (Eg Proton) Imaging Any Joint Of Lower Extremity; Without Contrast Material | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 73722 | Magnetic Resonance (Eg Proton) Imaging Any Joint Of Lower Extremity; 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. | _ | _ | _ |
| 73723 | Magnetic Resonance (Eg Proton) Imaging Any Joint Of Lower Extremity; 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. | _ | _ | _ |
| 73725 | Magnetic Resonance Angiography Lower Extremity 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. | _ | _ | _ |
| 74150 | Computed Tomography Abdomen; Without Contrast Material | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 74160 | Computed Tomography Abdomen; 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. | _ | _ | _ |

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| 74170 | Computed Tomography Abdomen; 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. | _ | _ | _ |
| 74174 | Computed Tomographic Angiography Abdomen And Pelvis 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. | _ | _ | _ |
| 74175 | Computed Tomographic Angiography Abdomen 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. | _ | _ | _ |
| 74176 | Computed Tomography Abdomen And Pelvis; Without Contrast Material | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 74177 | Computed Tomography Abdomen And Pelvis; 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. | _ | _ | _ |
| 74178 | Computed Tomography Abdomen And Pelvis; Without Contrast Material In One Or Both Body Regions Followed By Contrast Material(S) And Further Sections In One Or Both Body Regions | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 74181 | Magnetic Resonance (Eg Proton) Imaging Abdomen; 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. | _ | _ | _ |
| 74182 | Magnetic Resonance (Eg Proton) Imaging Abdomen; 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. | _ | _ | _ |
| 74183 | Magnetic Resonance (Eg Proton) Imaging Abdomen; Without Contrast Material(S) Followed By With 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. | _ | _ | _ |
| 74185 | Magnetic Resonance Angiography Abdomen 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. | _ | _ | _ |
| 74261 | Computed Tomographic (Ct) Colonography Diagnostic Including Image Postprocessing; Without Contrast Material | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 74262 | Computed Tomographic (Ct) Colonography Diagnostic Including Image Postprocessing; With Contrast Material(S) Including Non-Contrast Images If Performed | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 74263 | Computed Tomographic (Ct) Colonography Screening Including Image Postprocessing | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 74712 | Magnetic Resonance (Eg Proton) Imaging Fetal Including Placental And Maternal Pelvic Imaging When Performed; Single Or First Gestation | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 74713 | Magnetic Resonance (Eg Proton) Imaging Fetal Including Placental And Maternal Pelvic Imaging When Performed; Each Additional Gestation (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 BCBS. | _ | _ | _ |

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| 75635 | Computed Tomographic Angiography Abdominal Aorta And Bilateral Iliofemoral Lower Extremity Runoff 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. | _ | _ | _ |
| 75894 | Transcatheter Therapy Embolization Any Method Radiological Supervision And Interpretation | 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 |
| 76376 | 3D Rendering With Interpretation And Reporting Of Computed Tomography Magnetic Resonance Imaging Ultrasound Or Other Tomographic Modality With Image Postprocessing Under Concurrent Supervision; Not Requiring Image Postprocessing On An Independent Workstation | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 76377 | 3D Rendering With Interpretation And Reporting Of Computed Tomography Magnetic Resonance Imaging Ultrasound Or Other Tomographic Modality With Image Postprocessing Under Concurrent Supervision; Requiring Image Postprocessing On An Independent Workstation | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 76380 | Computed Tomography Limited Or Localized Follow-Up Study | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 76390 | Magnetic Resonance Spectroscopy | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 76391 | Magnetic Resonance (Eg Vibration) Elastography | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 76496 | Unlisted Fluoroscopic Procedure (Eg Diagnostic Interventional) | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| 76497 | Unlisted Computed Tomography Procedure (Eg Diagnostic Interventional) | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| 76498 | Unlisted Magnetic Resonance Procedure (Eg Diagnostic Interventional) | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| 76499 | Unlisted Diagnostic Radiographic Procedure | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| 76873 | Ultrasound Transrectal; Prostate Volume Study For Brachytherapy Treatment Planning (Separate Procedure) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 76965 | Ultrasonic Guidance For Interstitial Radioelement Application | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 76999 | Unlisted Ultrasound Procedure (Eg Diagnostic Interventional) | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| 77014 | Computed Tomography Guidance For Placement Of Radiation Therapy Fields | 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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| 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 Pharmacokinetic Analysis) When Performed; Unilateral | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 77049 | 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. | _ | _ | _ |

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| 77371 | Radiation Treatment Delivery Stereotactic Radiosurgery (Srs) Complete Course Of Treatment Of Cranial Lesion(S) Consisting Of 1 Session; Multi-Source Cobalt 60 Based | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 77372 | Radiation Treatment Delivery Stereotactic Radiosurgery (Srs) Complete Course Of Treatment Of Cranial Lesion(S) Consisting Of 1 Session; Linear Accelerator Based | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 77373 | Stereotactic Body Radiation Therapy Treatment Delivery Per Fraction To 1 Or More Lesions Including Image Guidance Entire Course Not To Exceed 5 Fractions | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 77385 | Intensity Modulated Radiation Treatment Delivery (Imrt) Includes Guidance And Tracking When Performed; Simple | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 77386 | Intensity Modulated Radiation Treatment Delivery (Imrt) Includes Guidance And Tracking When Performed; Complex | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 77387 | Guidance For Localization Of Target Volume For Delivery Of Radiation Treatment Includes Intrafraction Tracking When Performed | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 77399 | Unlisted Procedure Medical Radiation Physics Dosimetry And Treatment Devices And Special Services | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| 77402 | Radiation Treatment Delivery >=1 Mev; Simple | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 77407 | Radiation Treatment Delivery >=1 Mev; Intermediate | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 77412 | Radiation Treatment Delivery >=1 Mev; Complex | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 77424 | Intraoperative Radiation Treatment Delivery X-Ray Single Treatment Session | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 77425 | Intraoperative Radiation Treatment Delivery Electrons Single Treatment Session | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 77432 | Stereotactic Radiation Treatment Management Of Cranial Lesion(S) (Complete Course Of Treatment Consisting Of 1 Session) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 77435 | Stereotactic Body Radiation Therapy Treatment Management Per Treatment Course To 1 Or More Lesions Including Image Guidance Entire Course Not To Exceed 5 Fractions | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 77469 | Intraoperative Radiation Treatment Management | 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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| 77470 | Special Treatment Procedure (Eg Total Body Irradiation Hemibody Radiation Per Oral Or Endocavitary Irradiation) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 77499 | Unlisted Procedure Therapeutic Radiology Treatment Management | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| 77520 | Proton Treatment Delivery; Simple Without Compensation | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 77522 | Proton Treatment Delivery; Simple With Compensation | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 77523 | Proton Treatment Delivery; Intermediate | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 77525 | Proton Treatment Delivery; Complex | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 77750 | Infusion Or Instillation Of Radioelement Solution (Includes 3-Month Follow-Up Care) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 77761 | Intracavitary Radiation Source Application; Simple | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 77762 | Intracavitary Radiation Source Application; Intermediate | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 77763 | Intracavitary Radiation Source Application; Complex | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 77767 | Remote Afterloading High Dose Rate Radionuclide Skin Surface Brachytherapy Includes Basic Dosimetry When Performed; Lesion Diameter Up To 2.0 Cm Or 1 Channel | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 77768 | Remote Afterloading High Dose Rate Radionuclide Skin Surface Brachytherapy Includes Basic Dosimetry When Performed; Lesion Diameter Over 2.0 Cm And 2 Or More Channels Or Multiple Lesions | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 77770 | Remote Afterloading High Dose Rate Radionuclide Interstitial Or Intracavitary Brachytherapy Includes Basic Dosimetry When Performed; 1 Channel | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 77771 | Remote Afterloading High Dose Rate Radionuclide Interstitial Or Intracavitary Brachytherapy Includes Basic Dosimetry When Performed; 2-12 Channels | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 77772 | Remote Afterloading High Dose Rate Radionuclide Interstitial Or Intracavitary Brachytherapy Includes Basic Dosimetry When Performed; Over 12 Channels | 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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| 77778 | Interstitial Radiation Source Application Complex Includes Supervision Handling Loading Of Radiation Source When Performed | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 77790 | Supervision Handling Loading Of Radiation Source | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 77799 | Unlisted Procedure Clinical Brachytherapy | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| 78012 | Thyroid Uptake Single Or Multiple Quantitative Measurement(S) (Including Stimulation Suppression Or Discharge When Performed) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 78013 | Thyroid Imaging (Including Vascular Flow When Performed); | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 78014 | Thyroid Imaging (Including Vascular Flow When Performed); With Single Or Multiple Uptake(S) Quantitative Measurement(S) (Including Stimulation Suppression Or Discharge When Performed) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 78015 | Thyroid Carcinoma Metastases Imaging; Limited Area (Eg Neck And Chest Only) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 78016 | Thyroid Carcinoma Metastases Imaging; With Additional Studies (Eg Urinary Recovery) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 78018 | Thyroid Carcinoma Metastases Imaging; Whole Body | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 78020 | Thyroid Carcinoma Metastases Uptake (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 BCBS. | _ | _ | _ |
| 78070 | Parathyroid Planar Imaging (Including Subtraction When Performed); | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 78071 | Parathyroid Planar Imaging (Including Subtraction When Performed); With Tomographic (Spect) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 78072 | Parathyroid Planar Imaging (Including Subtraction When Performed); With Tomographic (Spect) And Concurrently Acquired Computed Tomography (Ct) For Anatomical Localization | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 78075 | Adrenal Imaging Cortex And/Or Medulla | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 78099 | Unlisted Endocrine Procedure Diagnostic Nuclear Medicine | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |

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| 78102 | Bone Marrow Imaging; Limited Area | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 78103 | Bone Marrow Imaging; Multiple Areas | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 78104 | Bone Marrow Imaging; Whole Body | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 78185 | Spleen Imaging Only  With Or Without Vascular Flow | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 78195 | Lymphatics And Lymph Nodes Imaging | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 78199 | Unlisted Hematopoietic  Reticuloendothelial And Lymphatic Procedure  Diagnostic Nuclear Medicine | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| 78201 | Liver Imaging; Static Only | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 78202 | Liver Imaging; With Vascular Flow | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 78215 | Liver And Spleen Imaging; Static Only | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 78216 | Liver And Spleen Imaging; With Vascular Flow | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 78226 | Hepatobiliary System Imaging  Including Gallbladder When Present; | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 78227 | Hepatobiliary System Imaging  Including Gallbladder When Present; With Pharmacologic Intervention  Including Quantitative Measurement(S) When Performed | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 78230 | Salivary Gland Imaging; | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 78231 | Salivary Gland Imaging; With Serial Images | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 78232 | Salivary Gland Function Study | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 78258 | Esophageal Motility | 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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| 78261 | Gastric Mucosa Imaging | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 78262 | Gastroesophageal Reflux Study | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 78264 | Gastric Emptying Imaging Study (Eg Solid Liquid Or Both); | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 78265 | Gastric Emptying Imaging Study (Eg Solid Liquid Or Both); With Small Bowel Transit | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 78266 | Gastric Emptying Imaging Study (Eg Solid Liquid Or Both); With Small Bowel And Colon Transit Multiple Days | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 78278 | Acute Gastrointestinal Blood Loss Imaging | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 78290 | Intestine Imaging (Eg Ectopic Gastric Mucosa Meckel'S Localization Volvulus) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 78291 | Peritoneal-Venous Shunt Patency Test (Eg For Leveen Denver Shunt) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 78299 | Unlisted Gastrointestinal Procedure Diagnostic Nuclear Medicine | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| 78300 | Bone And/Or Joint Imaging; Limited Area | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 78305 | Bone And/Or Joint Imaging; Multiple Areas | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 78306 | Bone And/Or Joint Imaging; Whole Body | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 78315 | Bone And/Or Joint Imaging; 3 Phase Study | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 78399 | Unlisted Musculoskeletal Procedure Diagnostic Nuclear Medicine | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| 78445 | Non-Cardiac Vascular Flow Imaging (Ie Angiography Venography) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 78456 | Acute Venous Thrombosis Imaging Peptide | 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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| 78457 | Venous Thrombosis Imaging Venogram; Unilateral | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 78458 | Venous Thrombosis Imaging Venogram; Bilateral | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 78499 | Unlisted Cardiovascular Procedure Diagnostic Nuclear Medicine | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| 78579 | Pulmonary Ventilation Imaging (Eg Aerosol Or Gas) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 78580 | Pulmonary Perfusion Imaging (Eg Particulate) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 78582 | Pulmonary Ventilation (Eg Aerosol Or Gas) And Perfusion Imaging | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 78597 | Quantitative Differential Pulmonary Perfusion Including Imaging When Performed | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 78598 | Quantitative Differential Pulmonary Perfusion And Ventilation (Eg Aerosol Or Gas) Including Imaging When Performed | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 78599 | Unlisted Respiratory Procedure Diagnostic Nuclear Medicine | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| 78600 | Brain Imaging Less Than 4 Static Views; | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 78601 | Brain Imaging Less Than 4 Static Views; With Vascular Flow | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 78605 | Brain Imaging Minimum 4 Static Views; | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 78606 | Brain Imaging Minimum 4 Static Views; With Vascular Flow | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 78608 | Brain Imaging Positron Emission Tomography (Pet); Metabolic Evaluation | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 78609 | Brain Imaging Positron Emission Tomography (Pet); Perfusion Evaluation | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 78610 | Brain Imaging Vascular Flow Only | 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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| 78630 | Cerebrospinal Fluid Flow Imaging (Not Including Introduction Of Material); Cisternography | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 78635 | Cerebrospinal Fluid Flow Imaging (Not Including Introduction Of Material); Ventriculography | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 78645 | Cerebrospinal Fluid Flow Imaging (Not Including Introduction Of Material); Shunt Evaluation | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 78650 | Cerebrospinal Fluid Leakage Detection And Localization | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 78660 | Radiopharmaceutical Dacryocystography | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 78699 | Unlisted Nervous System Procedure Diagnostic Nuclear Medicine | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| 78700 | Kidney Imaging Morphology; | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 78701 | Kidney Imaging Morphology; With Vascular Flow | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 78707 | Kidney Imaging Morphology; With Vascular Flow And Function Single Study Without Pharmacological Intervention | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 78708 | Kidney Imaging Morphology; With Vascular Flow And Function Single Study With Pharmacological Intervention (Eg Angiotensin Converting Enzyme Inhibitor And/Or Diuretic) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 78709 | Kidney Imaging Morphology; With Vascular Flow And Function Multiple Studies With And Without Pharmacological Intervention (Eg Angiotensin Converting Enzyme Inhibitor And/Or Diuretic) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 78725 | Kidney Function Study Non-Imaging Radioisotopic Study | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 78730 | Urinary Bladder Residual Study (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 BCBS. | _ | _ | _ |
| 78740 | Ureteral Reflux Study (Radiopharmaceutical Voiding Cystogram) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 78761 | Testicular Imaging With Vascular Flow | 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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| 78799 | Unlisted Genitourinary Procedure Diagnostic Nuclear Medicine | Unlisted: Procedure/service not specifically defined or 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. | _ | _ | _ |

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| 78816 | Positron Emission Tomography (Pet) With Concurrently Acquired Computed Tomography (Ct) For Attenuation Correction And Anatomical Localization Imaging; Whole Body | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 78830 | 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. | _ | _ | _ |

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

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| 81174 | Ar (Androgen Receptor) (Eg Spinal And Bulbar Muscular Atrophy Kennedy Disease X Chromosome Inactivation) 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. | _ | _ | _ |
| 81175 | Asxl1 (Additional Sex Combs Like 1 Transcriptional Regulator) (Eg Myelodysplastic Syndrome Myeloproliferative Neoplasms Chronic Myelomonocytic Leukemia) 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. | _ | _ | _ |
| 81176 | Asxl1 (Additional Sex Combs Like 1 Transcriptional Regulator) (Eg Myelodysplastic Syndrome Myeloproliferative Neoplasms Chronic Myelomonocytic Leukemia) Gene Analysis; Targeted Sequence Analysis (Eg Exon 12) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 81177 | Atn1 (Atrophin 1) (Eg Dentatorubral-Pallidoluysian Atrophy) 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. | _ | _ | _ |
| 81178 | Atxn1 (Ataxin 1) (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. | _ | _ | _ |
| 81179 | Atxn2 (Ataxin 2) (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. | _ | _ | _ |
| 81180 | Atxn3 (Ataxin 3) (Eg Spinocerebellar Ataxia Machado-Joseph Disease) 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. | _ | _ | _ |
| 81181 | Atxn7 (Ataxin 7) (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. | _ | _ | _ |
| 81182 | Atxn8Os (Atxn8 Opposite Strand [Non-Protein Coding]) (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. | _ | _ | _ |
| 81183 | Atxn10 (Ataxin 10) (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. | _ | _ | _ |
| 81184 | Cacna1A (Calcium Voltage-Gated Channel Subunit Alpha1 A) (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. | _ | _ | _ |
| 81185 | Cacna1A (Calcium Voltage-Gated Channel Subunit Alpha1 A) (Eg Spinocerebellar Ataxia) 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. | _ | _ | _ |
| 81186 | Cacna1A (Calcium Voltage-Gated Channel Subunit Alpha1 A) (Eg Spinocerebellar Ataxia) 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. | _ | _ | _ |
| 81187 | Cnbp (Cchc-Type Zinc Finger Nucleic Acid Binding Protein) (Eg Myotonic Dystrophy Type 2) 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. | _ | _ | _ |

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| 81188 | Cstb (Cystatin B) (Eg Unverricht-Lundborg Disease) 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. | _ | _ | _ |
| 81189 | Cstb (Cystatin B) (Eg Unverricht-Lundborg Disease) 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. | _ | _ | _ |
| 81190 | Cstb (Cystatin B) (Eg Unverricht-Lundborg Disease) Gene Analysis; Known Familial Variant(S) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 81191 | Ntrk1 (Neurotrophic Receptor Tyrosine Kinase 1) (Eg Solid Tumors) Translocation Analysis | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 81192 | Ntrk2 (Neurotrophic Receptor Tyrosine Kinase 2) (Eg Solid Tumors) Translocation Analysis | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 81193 | Ntrk3 (Neurotrophic Receptor Tyrosine Kinase 3) (Eg Solid Tumors) Translocation Analysis | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 81194 | Ntrk (Neurotrophic Receptor Tyrosine Kinase 1 2 And 3) (Eg Solid Tumors) Translocation Analysis | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 81200 | Aspa (Aspartoacylase) (Eg Canavan Disease) Gene Analysis Common Variants (Eg E285A Y231X) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 81201 | Apc (Adenomatous Polyposis Coli) (Eg Familial Adenomatosis Polyposis [Fap] Attenuated Fap) 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. | _ | _ | _ |
| 81202 | Apc (Adenomatous Polyposis Coli) (Eg Familial Adenomatosis Polyposis [Fap] Attenuated Fap) 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. | _ | _ | _ |
| 81203 | Apc (Adenomatous Polyposis Coli) (Eg Familial Adenomatosis Polyposis [Fap] Attenuated Fap) 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. | _ | _ | _ |
| 81204 | Ar (Androgen Receptor) (Eg Spinal And Bulbar Muscular Atrophy Kennedy Disease X Chromosome Inactivation) Gene Analysis; Characterization Of Alleles (Eg Expanded Size Or Methylation Status) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 81205 | Bckdhb (Branched-Chain Keto Acid Dehydrogenase E1 Beta Polypeptide) (Eg Maple Syrup Urine Disease) Gene Analysis Common Variants (Eg R183P G278S E422X) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 81208 | Bcr/Abl1 (T(9;22)) (Eg Chronic Myelogenous Leukemia) Translocation Analysis; Other Breakpoint Qualitative Or Quantitative | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 81209 | Blm (Bloom Syndrome Recq Helicase-Like) (Eg Bloom Syndrome) Gene Analysis 2281Del6Ins7 Variant | 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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| 81210 | Braf (B-Raf Proto-Oncogene Serine/Threonine Kinase) (Eg Colon Cancer Melanoma) Gene Analysis V600 Variant(S) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 81212 | Brca1 (Brca1 Dna Repair Associated) Brca2 (Brca2 Dna Repair Associated) (Eg Hereditary Breast And Ovarian Cancer) Gene Analysis; 185Delag 5385Insc 6174Delt Variants | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 81215 | Brca1 (Brca1 Dna Repair Associated) (Eg Hereditary Breast And Ovarian Cancer) 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. | _ | _ | _ |
| 81216 | Brca2 (Brca2 Dna Repair Associated) (Eg Hereditary Breast And Ovarian Cancer) 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. | _ | _ | _ |
| 81217 | Brca2 (Brca2 Dna Repair Associated) (Eg Hereditary Breast And Ovarian Cancer) 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. | _ | _ | _ |
| 81218 | Cebpa (Ccaat/Enhancer Binding Protein [C/Ebp] Alpha) (Eg Acute Myeloid Leukemia) 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. | _ | _ | _ |
| 81219 | Calr (Calreticulin) (Eg Myeloproliferative Disorders) Gene Analysis Common Variants In Exon 9 | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 81221 | Cftr (Cystic Fibrosis Transmembrane Conductance Regulator) (Eg Cystic Fibrosis) 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. | _ | _ | _ |
| 81222 | Cftr (Cystic Fibrosis Transmembrane Conductance Regulator) (Eg Cystic Fibrosis) 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. | _ | _ | _ |
| 81223 | Cftr (Cystic Fibrosis Transmembrane Conductance Regulator) (Eg Cystic Fibrosis) 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. | _ | _ | _ |
| 81224 | Cftr (Cystic Fibrosis Transmembrane Conductance Regulator) (Eg Cystic Fibrosis) Gene Analysis; Intron 8 Poly-T Analysis (Eg Male Infertility) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 81225 | Cyp2C19 (Cytochrome P450 Family 2 Subfamily C Polypeptide 19) (Eg Drug Metabolism) Gene Analysis Common Variants (Eg *2 *3 *4 *8 *17) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 81226 | Cyp2D6 (Cytochrome P450 Family 2 Subfamily D Polypeptide 6) (Eg Drug Metabolism) Gene Analysis Common Variants (Eg *2 *3 *4 *5 *6 *9 *10 *17 *19 *29 *35 *41 *1Xn *2Xn *4Xn) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 81227 | Cyp2C9 (Cytochrome P450 Family 2 Subfamily C Polypeptide 9) (Eg Drug Metabolism) Gene Analysis Common Variants (Eg *2 *3 *5 *6) | 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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| 81228 | Cytogenomic (Genome-Wide) Analysis For Constitutional Chromosomal Abnormalities; Interrogation Of Genomic Regions For Copy Number Variants Comparative Genomic Hybridization [Cgh] Microarray Analysis | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 81229 | Cytogenomic (Genome-Wide) Analysis For Constitutional Chromosomal Abnormalities; Interrogation Of Genomic Regions For Copy Number And Single Nucleotide Polymorphism (Snp) Variants Comparative Genomic Hybridization (Cgh) Microarray Analysis | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 81230 | Cyp3A4 (Cytochrome P450 Family 3 Subfamily A Member 4) (Eg Drug Metabolism) Gene Analysis Common Variant(S) (Eg *2 *22) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 81231 | Cyp3A5 (Cytochrome P450 Family 3 Subfamily A Member 5) (Eg Drug Metabolism) Gene Analysis Common Variants (Eg *2 *3 *4 *5 *6 *7) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 81232 | Dpyd (Dihydropyrimidine Dehydrogenase) (Eg 5-Fluorouracil/5-Fu And Capecitabine Drug Metabolism) Gene Analysis Common Variant(S) (Eg *2A *4 *5 *6) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 81233 | Btk (Bruton'S Tyrosine Kinase) (Eg Chronic Lymphocytic Leukemia) Gene Analysis Common Variants (Eg C481S C481R C481F) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 81234 | Dmpk (Dm1 Protein Kinase) (Eg Myotonic Dystrophy Type 1) Gene Analysis; Evaluation To Detect Abnormal (Expanded) Alleles | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 81235 | Egfr (Epidermal Growth Factor Receptor) (Eg Non-Small Cell Lung Cancer) Gene Analysis Common Variants (Eg Exon 19 Lrea Deletion L858R T790M G719A G719S L861Q) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 81236 | Ezh2 (Enhancer Of Zeste 2 Polycomb Repressive Complex 2 Subunit) (Eg Myelodysplastic Syndrome Myeloproliferative Neoplasms) 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. | _ | _ | _ |
| 81237 | Ezh2 (Enhancer Of Zeste 2 Polycomb Repressive Complex 2 Subunit) (Eg Diffuse Large B-Cell Lymphoma) Gene Analysis Common Variant(S) (Eg Codon 646) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 81238 | F9 (Coagulation Factor Ix) (Eg Hemophilia B) Full Gene Sequence | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 81239 | Dmpk (Dm1 Protein Kinase) (Eg Myotonic Dystrophy Type 1) Gene Analysis; Characterization Of Alleles (Eg Expanded Size) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 81240 | F2 (Prothrombin Coagulation Factor Ii) (Eg Hereditary Hypercoagulability) Gene Analysis 20210G>A Variant | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 81242 | Fancc (Fanconi Anemia Complementation Group C) (Eg Fanconi Anemia Type C) Gene Analysis Common Variant (Eg Ivs4+4A>T) | 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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| 81244 | Fmr1 (Fragile X Messenger Ribonucleoprotein 1) (Eg Fragile X Syndrome X-Linked Intellectual Disability [Xlid]) Gene Analysis; Characterization Of Alleles (Eg Expanded Size And Promoter Methylation Status) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 81245 | Flt3 (Fms-Related Tyrosine Kinase 3) (Eg Acute Myeloid Leukemia) Gene Analysis; Internal Tandem Duplication (Itd) Variants (Ie Exons 14 15) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 81246 | Flt3 (Fms-Related Tyrosine Kinase 3) (Eg Acute Myeloid Leukemia) Gene Analysis; Tyrosine Kinase Domain (Tkd) Variants (Eg D835 I836) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 81247 | G6Pd (Glucose-6-Phosphate Dehydrogenase) (Eg Hemolytic Anemia Jaundice) Gene Analysis; Common Variant(S) (Eg A A-) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 81248 | G6Pd (Glucose-6-Phosphate Dehydrogenase) (Eg Hemolytic Anemia Jaundice) Gene Analysis; Known Familial Variant(S) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 81249 | G6Pd (Glucose-6-Phosphate Dehydrogenase) (Eg Hemolytic Anemia Jaundice) 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. | _ | _ | _ |
| 81250 | G6Pc (Glucose-6-Phosphatase Catalytic Subunit) (Eg Glycogen Storage Disease Type 1A Von Gierke Disease) Gene Analysis Common Variants (Eg R83C Q347X) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 81251 | Gba (Glucosidase Beta Acid) (Eg Gaucher Disease) Gene Analysis Common Variants (Eg N370S 84Gg L444P Ivs2+1G>A) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 81252 | Gjb2 (Gap Junction Protein Beta 2 26Kda Connexin 26) (Eg Nonsyndromic Hearing Loss) 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. | _ | _ | _ |
| 81253 | Gjb2 (Gap Junction Protein Beta 2 26Kda Connexin 26) (Eg Nonsyndromic Hearing Loss) 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. | _ | _ | _ |
| 81254 | Gjb6 (Gap Junction Protein Beta 6 30Kda Connexin 30) (Eg Nonsyndromic Hearing Loss) Gene Analysis Common Variants (Eg 309Kb [Del(Gjb6-D13S1830)] And 232Kb [Del(Gjb6-D13S1854)]) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 81255 | Hexa (Hexosaminidase A [Alpha Polypeptide]) (Eg Tay-Sachs Disease) Gene Analysis Common Variants (Eg 1278Instatc 1421+1G>C G269S) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 81256 | Hfe (Hemochromatosis) (Eg Hereditary Hemochromatosis) Gene Analysis Common Variants (Eg C282Y H63D) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 81257 | Hba1/Hba2 (Alpha Globin 1 And Alpha Globin 2) (Eg Alpha Thalassemia Hb Bart Hydrops Fetalis Syndrome Hbh Disease) Gene Analysis; Common Deletions Or Variant (Eg Southeast Asian Thai Filipino Mediterranean Alpha3.7 Alpha4.2 Alpha20.5 Constant Spring) | 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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| 81258 | Hba1/Hba2 (Alpha Globin 1 And Alpha Globin 2) (Eg Alpha Thalassemia Hb Bart Hydrops Fetalis Syndrome Hbh Disease) 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. | _ | _ | _ |
| 81259 | Hba1/Hba2 (Alpha Globin 1 And Alpha Globin 2) (Eg Alpha Thalassemia Hb Bart Hydrops Fetalis Syndrome Hbh Disease) 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. | _ | _ | _ |
| 81260 | Ikbkap (Inhibitor Of Kappa Light Polypeptide Gene Enhancer In B-Cells Kinase Complex-Associated Protein) (Eg Familial Dysautonomia) Gene Analysis Common Variants (Eg 2507+6T>C R696P) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 81261 | Igh@ (Immunoglobulin Heavy Chain Locus) (Eg Leukemias And Lymphomas B-Cell) Gene Rearrangement Analysis To Detect Abnormal Clonal Population(S); Amplified 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. | _ | _ | _ |
| 81262 | Igh@ (Immunoglobulin Heavy Chain Locus) (Eg Leukemias And Lymphomas B-Cell) Gene Rearrangement Analysis To Detect Abnormal Clonal Population(S); 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. | _ | _ | _ |
| 81263 | Igh@ (Immunoglobulin Heavy Chain Locus) (Eg Leukemia And Lymphoma B-Cell) Variable Region Somatic Mutation Analysis | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 81264 | Igk@ (Immunoglobulin Kappa Light Chain Locus) (Eg Leukemia And Lymphoma B-Cell) 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. | _ | _ | _ |
| 81265 | Comparative Analysis Using Short Tandem Repeat (Str) Markers; Patient And Comparative Specimen (Eg Pre-Transplant Recipient And Donor Germline Testing Post-Transplant Non-Hematopoietic Recipient Germline [Eg Buccal Swab Or Other Germline Tissue Sample] And Donor Testing Twin Zygosity Testing Or Maternal Cell Contamination Of Fetal Cells) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 81266 | Comparative Analysis Using Short Tandem Repeat (Str) Markers; Each Additional Specimen (Eg Additional Cord Blood Donor Additional Fetal Samples From Different Cultures Or Additional Zygosity In Multiple Birth Pregnancies) (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. | _ | _ | _ |
| 81269 | Hba1/Hba2 (Alpha Globin 1 And Alpha Globin 2) (Eg Alpha Thalassemia Hb Bart Hydrops Fetalis Syndrome Hbh Disease) 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. | _ | _ | _ |
| 81270 | Jak2 (Janus Kinase 2) (Eg Myeloproliferative Disorder) Gene Analysis P.Val617Phe (V617F) Variant | 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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| 81271 | Htt (Huntingtin) (Eg Huntington Disease) 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. | _ | _ | _ |
| 81272 | Kit (V-Kit Hardy-Zuckerman 4 Feline Sarcoma Viral Oncogene Homolog) (Eg Gastrointestinal Stromal Tumor [Gist] Acute Myeloid Leukemia Melanoma) Gene Analysis Targeted Sequence Analysis (Eg Exons 8 11 13 17 18) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 81273 | Kit (V-Kit Hardy-Zuckerman 4 Feline Sarcoma Viral Oncogene Homolog) (Eg Mastocytosis) Gene Analysis D816 Variant(S) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 81274 | Htt (Huntingtin) (Eg Huntington Disease) Gene Analysis; Characterization Of Alleles (Eg Expanded Size) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 81275 | Kras (Kirsten Rat Sarcoma Viral Oncogene Homolog) (Eg Carcinoma) Gene Analysis; Variants In Exon 2 (Eg Codons 12 And 13) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 81276 | Kras (Kirsten Rat Sarcoma Viral Oncogene Homolog) (Eg Carcinoma) Gene Analysis; Additional Variant(S) (Eg Codon 61 Codon 146) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 81277 | Cytogenomic Neoplasia (Genome-Wide) Microarray Analysis Interrogation Of Genomic Regions For Copy Number And Loss-Of-Heterozygosity Variants For Chromosomal Abnormalities | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 81278 | Igh@/Bcl2 (T(14;18)) (Eg Follicular Lymphoma) Translocation Analysis Major Breakpoint Region (Mbr) And Minor Cluster Region (Mcr) Breakpoints Qualitative Or Quantitative | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 81279 | Jak2 (Janus Kinase 2) (Eg Myeloproliferative Disorder) Targeted Sequence Analysis (Eg Exons 12 And 13) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 81283 | Ifnl3 (Interferon Lambda 3) (Eg Drug Response) Gene Analysis Rs12979860 Variant | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 81284 | Fxn (Frataxin) (Eg Friedreich Ataxia) Gene Analysis; Evaluation To Detect Abnormal (Expanded) Alleles | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 81285 | Fxn (Frataxin) (Eg Friedreich Ataxia) Gene Analysis; Characterization Of Alleles (Eg Expanded Size) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 81286 | Fxn (Frataxin) (Eg Friedreich Ataxia) 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. | _ | _ | _ |
| 81287 | Mgmt (O-6-Methylguanine-Dna Methyltransferase) (Eg Glioblastoma Multiforme) Promoter Methylation 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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| 81288 | Mlh1 (Mutl Homolog 1 Colon Cancer Nonpolyposis Type 2) (Eg Hereditary Non-Polyposis Colorectal Cancer Lynch Syndrome) Gene Analysis; Promoter Methylation Analysis | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 81289 | Fxn (Frataxin) (Eg Friedreich Ataxia) Gene Analysis; Known Familial Variant(S) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 81290 | Mcoln1 (Mucolipin 1) (Eg Mucolipidosis Type Iv) Gene Analysis Common Variants (Eg Ivs3-2A>G Del6.4Kb) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 81291 | Mthfr (5 10-Methylenetetrahydrofolate Reductase) (Eg Hereditary Hypercoagulability) Gene Analysis Common Variants (Eg 677T 1298C) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 81292 | Mlh1 (Mutl Homolog 1 Colon Cancer Nonpolyposis Type 2) (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. | _ | _ | _ |
| 81293 | Mlh1 (Mutl Homolog 1 Colon Cancer Nonpolyposis Type 2) (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. | _ | _ | _ |
| 81294 | Mlh1 (Mutl Homolog 1 Colon Cancer Nonpolyposis Type 2) (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. | _ | _ | _ |
| 81295 | Msh2 (Muts Homolog 2 Colon Cancer Nonpolyposis Type 1) (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. | _ | _ | _ |
| 81296 | Msh2 (Muts Homolog 2 Colon Cancer Nonpolyposis Type 1) (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. | _ | _ | _ |
| 81297 | Msh2 (Muts Homolog 2 Colon Cancer Nonpolyposis Type 1) (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. | _ | _ | _ |
| 81298 | Msh6 (Muts Homolog 6 [E. Coli]) (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. | _ | _ | _ |
| 81299 | Msh6 (Muts Homolog 6 [E. Coli]) (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. | _ | _ | _ |
| 81300 | Msh6 (Muts Homolog 6 [E. Coli]) (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. | _ | _ | _ |
| 81301 | Microsatellite Instability Analysis (Eg Hereditary Non-Polyposis Colorectal Cancer Lynch Syndrome) Of Markers For Mismatch Repair Deficiency (Eg Bat25 Bat26) Includes Comparison Of Neoplastic And Normal Tissue If Performed | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 81302 | Mecp2 (Methyl Cpg Binding Protein 2) (Eg Rett 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. | _ | _ | _ |

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

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| 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. | _ | _ | _ |

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| 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. | _ | _ | _ |

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| 81345 | Tert (Telomerase Reverse Transcriptase) (Eg Thyroid Carcinoma Glioblastoma Multiforme) Gene Analysis Targeted Sequence Analysis (Eg Promoter Region) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 81346 | Tyms (Thymidylate Synthetase) (Eg 5-Fluorouracil/5-Fu Drug Metabolism) Gene Analysis Common Variant(S) (Eg Tandem Repeat Variant) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 81347 | Sf3B1 (Splicing Factor [3B] Subunit B1) (Eg Myelodysplastic Syndrome/Acute Myeloid Leukemia) Gene Analysis Common Variants (Eg A672T E622D L833F R625C R625L) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 81348 | Srsf2 (Serine And Arginine-Rich Splicing Factor 2) (Eg Myelodysplastic Syndrome Acute Myeloid Leukemia) Gene Analysis Common Variants (Eg P95H P95L) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 81349 | Cytogenomic (Genome-Wide) Analysis For Constitutional Chromosomal Abnormalities; Interrogation Of Genomic Regions For Copy Number And Loss-Of-Heterozygosity Variants Low-Pass Sequencing Analysis | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 81350 | Ugt1A1 (Udp Glucuronosyltransferase 1 Family Polypeptide A1) (Eg Drug Metabolism Hereditary Unconjugated Hyperbilirubinemia [Gilbert Syndrome]) Gene Analysis Common Variants (Eg *28 *36 *37) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 81351 | Tp53 (Tumor Protein 53) (Eg Li-Fraumeni Syndrome) 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. | _ | _ | _ |
| 81352 | Tp53 (Tumor Protein 53) (Eg Li-Fraumeni Syndrome) Gene Analysis; Targeted Sequence Analysis (Eg 4 Oncology) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 81353 | Tp53 (Tumor Protein 53) (Eg Li-Fraumeni 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. | _ | _ | _ |
| 81355 | Vkorc1 (Vitamin K Epoxide Reductase Complex Subunit 1) (Eg Warfarin Metabolism) Gene Analysis Common Variant(S) (Eg -1639G>A C.173+1000C>T) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 81357 | U2Af1 (U2 Small Nuclear Rna Auxiliary Factor 1) (Eg Myelodysplastic Syndrome Acute Myeloid Leukemia) Gene Analysis Common Variants (Eg S34F S34Y Q157R Q157P) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 81360 | Zrsr2 (Zinc Finger Ccch-Type Rna Binding Motif And Serine/Arginine-Rich 2) (Eg Myelodysplastic Syndrome Acute Myeloid Leukemia) Gene Analysis Common Variant(S) (Eg E65Fs E122Fs R448Fs) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 81361 | Hbb (Hemoglobin Subunit Beta) (Eg Sickle Cell Anemia Beta Thalassemia Hemoglobinopathy); Common Variant(S) (Eg Hbs Hbc Hbe) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 81362 | Hbb (Hemoglobin Subunit Beta) (Eg Sickle Cell Anemia Beta Thalassemia Hemoglobinopathy); Known Familial Variant(S) | 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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| 81363 | Hbb (Hemoglobin Subunit Beta) (Eg Sickle Cell Anemia Beta Thalassemia Hemoglobinopathy); Duplication/Deletion Variant(S) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 81364 | Hbb (Hemoglobin Subunit Beta) (Eg Sickle Cell Anemia Beta Thalassemia Hemoglobinopathy); Full Gene Sequence | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 81400 | Molecular Pathology Procedure Level 1 (Eg Identification Of 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 Ii 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 [Serum Prothrombin Conversion Accelerator]) (Eg Hereditary Hypercoagulability) R353Q Variant F13B (Coagulation Factor Xiii B Polypeptide) (Eg Hereditary 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 | 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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| 81401 | 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 Myeloid Leukemia) Qualitative And Quantitative If Performed Cbs (Cystathionine-Beta-Synthase) (Eg Homocystinuria Cystathionine Beta-Synthase Deficiency) Common Variants (Eg I278T 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 Eml4/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 | 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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| 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 (Ie 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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| 81403 | 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 Leukemia) Targeted Sequence Analysis (Eg Exon 23) Epcam (Epithelial Cell Adhesion Molecule) (Eg Lynch Syndrome) 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 Gnaq (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 | 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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| 81404 | 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 Gene Sequence Cav3 (Caveolin 3) (Eg Cav3-Related Distal Myopathy Limb-Girdle Muscular Dystrophy Type 1C) Full 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 | 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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| 81405 | 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 1A) Full Gene Sequence Bcs1L (Bcs1-Like [S. Cerevisiae]) (Eg Leigh Syndrome Mitochondrial Complex Iii Deficiency 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 ( | 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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| 81406 | 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 Citrullinemia Type I) Full Gene Sequence Atl1 (Atlastin Gtpase 1) (Eg Spastic Paraplegia) Full Gene Sequence 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 | 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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| 81407 | 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 Alport Syndrome) Duplication/Deletion Analysis Col6A1 (Collagen Type Vi Alpha 1) (Eg Collagen Type Vi-Related 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 | 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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| 81408 | 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 Dystrophy) Full Gene Sequence Dysf (Dysferlin Limb Girdle Muscular Dystrophy 2B [Autosomal Recessive]) (Eg Limb-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 | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 81410 | Aortic Dysfunction Or Dilation (Eg Marfan Syndrome Loeys Dietz Syndrome Ehler Danlos Syndrome Type Iv Arterial Tortuosity Syndrome); Genomic Sequence Analysis Panel Must Include Sequencing Of At Least 9 Genes Including Fbn1 Tgfbr1 Tgfbr2 Col3A1 Myh11 Acta2 Slc2A10 Smad3 And Mylk | 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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| 81411 | Aortic Dysfunction Or Dilation (Eg Marfan Syndrome Loeys Dietz Syndrome Ehler Danlos Syndrome Type Iv Arterial Tortuosity Syndrome); Duplication/Deletion Analysis Panel Must Include Analyses For Tgfbr1 Tgfbr2 Myh11 And Col3A1 | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 81412 | Ashkenazi Jewish Associated Disorders (Eg Bloom Syndrome Canavan Disease Cystic Fibrosis Familial Dysautonomia Fanconi Anemia Group C Gaucher Disease Tay-Sachs Disease) Genomic Sequence Analysis Panel Must Include Sequencing Of At Least 9 Genes Including Aspa Blm Cftr Fancc Gba Hexa Ikbkap Mcoln1 And Smpd1 | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 81413 | Cardiac Ion Channelopathies (Eg Brugada Syndrome Long Qt Syndrome Short Qt Syndrome Catecholaminergic Polymorphic Ventricular Tachycardia); Genomic Sequence Analysis Panel Must Include Sequencing Of At Least 10 Genes Including Ank2 Casq2 Cav3 Kcne1 Kcne2 Kcnh2 Kcnj2 Kcnq1 Ryr2 And Scn5A | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 81414 | Cardiac Ion Channelopathies (Eg Brugada Syndrome Long Qt Syndrome Short Qt Syndrome Catecholaminergic Polymorphic Ventricular Tachycardia); Duplication/Deletion Gene Analysis Panel Must Include Analysis Of At Least 2 Genes Including Kcnh2 And Kcnq1 | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 81415 | Exome (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. | _ | _ | _ |
| 81416 | Exome (Eg Unexplained Constitutional Or Heritable Disorder Or Syndrome); Sequence Analysis Each Comparator Exome (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. | _ | _ | _ |
| 81417 | Exome (Eg Unexplained Constitutional Or Heritable Disorder Or Syndrome); Re-Evaluation Of Previously Obtained Exome 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. | _ | _ | _ |
| 81418 | Drug Metabolism (Eg Pharmacogenomics) Genomic Sequence Analysis Panel Must Include Testing Of At Least 6 Genes Including Cyp2C19 Cyp2D6 And Cyp2D6 Duplication/Deletion Analysis | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 81419 | Epilepsy Genomic Sequence Analysis Panel Must Include Analyses For Aldh7A1 Cacna1A Cdkl5 Chd2 Gabrg2 Grin2A Kcnq2 Mecp2 Pcdh19 Polg Prrt2 Scn1A Scn1B Scn2A Scn8A Slc2A1 Slc9A6 Stxbp1 Syngap1 Tcf4 Tpp1 Tsc1 Tsc2 And Zeb2 | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 81422 | Fetal Chromosomal Microdeletion(S) Genomic Sequence Analysis (Eg Digeorge Syndrome Cri-Du-Chat Syndrome) 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. | _ | _ | _ |

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| 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. | _ | _ | _ |

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| 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. | _ | _ | _ |

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| 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. | _ | _ | _ |

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| 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 Detection | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 81465 | 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 Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 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. | _ | _ | _ |

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| 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. | _ | _ | _ |

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| 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 | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 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). | _ | _ | _ |

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

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

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| 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 And Spinal Cord | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| 88012 | Necropsy (Autopsy)  Gross Examination Only; Infant With Brain | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| 88014 | Necropsy (Autopsy)  Gross Examination Only; Stillborn Or Newborn With Brain | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| 88016 | Necropsy (Autopsy)  Gross Examination Only; Macerated Stillborn | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| 88020 | Necropsy (Autopsy)  Gross And Microscopic; Without Cns | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| 88025 | Necropsy (Autopsy)  Gross And Microscopic; With Brain | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| 88027 | Necropsy (Autopsy)  Gross And Microscopic; With Brain And Spinal Cord | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| 88028 | Necropsy (Autopsy)  Gross And Microscopic; Infant With Brain | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| 88029 | Necropsy (Autopsy)  Gross And Microscopic; Stillborn Or Newborn With Brain | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| 88036 | Necropsy (Autopsy)  Limited  Gross And/Or Microscopic; Regional | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| 88037 | Necropsy (Autopsy)  Limited  Gross And/Or Microscopic; Single Organ | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| 88040 | Necropsy (Autopsy); Forensic Examination | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| 88045 | Necropsy (Autopsy); Coroner'S Call | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| 88099 | Unlisted Necropsy (Autopsy) Procedure | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted or Undefined: Procedures/services not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| 88199 | Unlisted Cytopathology Procedure | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| 88299 | Unlisted Cytogenetic Study | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| 88375 | Optical Endomicroscopic Image(S)  Interpretation And Report  Real-Time Or Referred  Each Endoscopic Session | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our  Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| 88399 | Unlisted Surgical Pathology Procedure | Unlisted: Procedure/service not specifically defined or 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. | _ | _ | _ |

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| 89240 | Unlisted Miscellaneous Pathology Test | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| 89258 | Cryopreservation; Embryo(S) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | | 4/23/2024 | Retire effective 4/23/2024 |
| 89258 | Cryopreservation; Embryo(S) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/24/2024 | _ | Effective 4/24/2024 |
| 89259 | Cryopreservation; Sperm | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 89335 | Cryopreservation Reproductive Tissue Testicular | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 89337 | Cryopreservation Mature Oocyte(S) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 89342 | Storage (Per Year); Embryo(S) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 89343 | Storage (Per Year); Sperm/Semen | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 89344 | Storage (Per Year); Reproductive Tissue Testicular/Ovarian | MP Criteria: Procedure/service reviewed against Medical 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. Not subject to pre-service review. | | 4/23/2024 | Retire effective 4/23/2024 |
| 89346 | Storage (Per Year); Oocyte(S) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/24/2024 | _ | Effective 4/24/2024 |
| 89398 | Unlisted Reproductive Medicine Laboratory Procedure | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| 90378 | Respiratory Syncytial Virus Monoclonal Antibody Recombinant For Intramuscular Use 50 Mg Each | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | _ | _ | _ |
| 90399 | Unlisted Immune Globulin | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| 90584 | Dengue Vaccine Quadrivalent Live 2 Dose Schedule For Subcutaneous Use | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| 90689 | Influenza Virus Vaccine Quadrivalent (Iiv4) Inactivated Adjuvanted Preservative Free 0.25 Ml Dosage For Intramuscular Use | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| 90749 | Unlisted Vaccine/Toxoid | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |

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

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

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

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| 92622 | Diagnostic Analysis Programming And Verification Of An Auditory Osseointegrated Sound Processor Any Type; First 60 Minutes | 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 |
| 92623 | Diagnostic Analysis Programming And Verification Of An Auditory Osseointegrated Sound Processor Any Type; Each Additional 15 Minutes (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. | 4/1/2024 | _ | Add effective 04/01/2024 |
| 92633 | Auditory Rehabilitation; Postlingual Hearing Loss | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 92640 | Diagnostic Analysis With Programming Of Auditory Brainstem Implant Per Hour | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 92700 | Unlisted Otorhinolaryngological Service Or Procedure | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| 92972 | Percutaneous Transluminal Coronary Lithotripsy (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. | 4/1/2024 | _ | Add effective 04/01/2024 |
| 93050 | Arterial Pressure Waveform Analysis For Assessment Of Central Arterial Pressures Includes Obtaining Waveform(S) Digitization And Application Of Nonlinear Mathematical Transformations To Determine Central Arterial Pressures And Augmentation Index With Interpretation And Report Upper Extremity Artery Non-Invasive | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| 93150 | Therapy Activation Of Implanted Phrenic Nerve Stimulator System Including All Interrogation And Programming | EIU: Procedure/service not 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 |
| 93150 | Therapy Activation Of Implanted Phrenic Nerve Stimulator System Including All Interrogation And Programming | 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<br>Retire effective 05/14/2024 |
| 93151 | Interrogation And Programming (Minimum One Parameter) Of Implanted Phrenic Nerve Stimulator System | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024 | _ | Add effective 05/15/2024 |
| 93151 | Interrogation And Programming (Minimum One Parameter) Of Implanted Phrenic Nerve Stimulator System | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2024 | 5/14/2024 | Add effective 02/15/2024<br>Retire effective 05/14/2024 |
| 93152 | Interrogation And Programming Of Implanted Phrenic Nerve Stimulator System During Polysomnography | EIU: Procedure/service not 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 |
| 93152 | Interrogation And Programming Of Implanted Phrenic Nerve Stimulator System During Polysomnography | 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<br>Retire effective 05/14/2024 |
| 93153 | Interrogation Without Programming Of Implanted Phrenic Nerve Stimulator System | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024 | _ | Add effective 05/15/2024 |

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| 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 avoid post-service review. | 2/15/2024 | 5/14/2024 | Add effective 02/15/2024<br>Retire effective 05/14/2024 |
| 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 | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 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. | _ | _ | _ |

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| 93998 | Unlisted Noninvasive Vascular Diagnostic Study | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| 94014 | Patient-Initiated Spirometric Recording Per 30-Day Period Of Time; Includes Reinforced Education Transmission Of Spirometric Tracing Data Capture Analysis Of Transmitted Data Periodic Recalibration And Review And Interpretation 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). | _ | _ | _ |
| 94015 | Patient-Initiated Spirometric Recording Per 30-Day Period Of Time; Recording (Includes Hook-Up Reinforced Education Data Transmission Data Capture Trend Analysis And Periodic Recalibration) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| 94016 | Patient-Initiated Spirometric Recording Per 30-Day Period Of Time; Review And Interpretation Only 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). | _ | _ | _ |
| 94452 | High Altitude Simulation Test (Hast) With Interpretation And Report By A Physician Or Other Qualified Health Care Professional; | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| 94453 | High Altitude Simulation Test (Hast) With Interpretation And Report By A Physician Or Other Qualified Health Care Professional; With Supplemental Oxygen Titration | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| 94799 | Unlisted Pulmonary Service Or Procedure | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| 95060 | Ophthalmic Mucous Membrane Tests | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| 95065 | Direct Nasal Mucous Membrane Test | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| 95199 | Unlisted Allergy/Clinical Immunologic Service Or Procedure | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| 95700 | Electroencephalogram (Eeg) Continuous Recording With Video When Performed Setup Patient Education And Takedown When Performed Administered In Person By Eeg Technologist Minimum Of 8 Channels | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 95705 | Electroencephalogram (Eeg) Without Video Review Of Data Technical Description By Eeg Technologist 2-12 Hours; Unmonitored | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 95706 | Electroencephalogram (Eeg) Without Video Review Of Data Technical Description By Eeg Technologist 2-12 Hours; With Intermittent Monitoring And Maintenance | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 95707 | Electroencephalogram (Eeg) Without Video Review Of Data Technical Description By Eeg Technologist 2-12 Hours; With Continuous Real-Time Monitoring And Maintenance | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |

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| 95708 | Electroencephalogram (Eeg) Without Video Review Of Data Technical Description By Eeg Technologist Each Increment Of 12-26 Hours; Unmonitored | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 95709 | Electroencephalogram (Eeg) Without Video Review Of Data Technical Description By Eeg Technologist Each Increment Of 12-26 Hours; With Intermittent Monitoring And Maintenance | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 95710 | Electroencephalogram (Eeg) Without Video Review Of Data Technical Description By Eeg Technologist Each Increment Of 12-26 Hours; With Continuous Real-Time Monitoring And Maintenance | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 95711 | Electroencephalogram With Video (Veeg) Review Of Data Technical Description By Eeg Technologist 2-12 Hours; Unmonitored | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 95712 | Electroencephalogram With Video (Veeg) Review Of Data Technical Description By Eeg Technologist 2-12 Hours; With Intermittent Monitoring And Maintenance | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 95713 | Electroencephalogram With Video (Veeg) Review Of Data Technical Description By Eeg Technologist 2-12 Hours; With Continuous Real-Time Monitoring And Maintenance | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 95714 | Electroencephalogram With Video (Veeg) Review Of Data Technical Description By Eeg Technologist Each Increment Of 12-26 Hours; Unmonitored | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 95715 | Electroencephalogram With Video (Veeg) Review Of Data Technical Description By Eeg Technologist Each Increment Of 12-26 Hours; With Intermittent Monitoring And Maintenance | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 95716 | Electroencephalogram With Video (Veeg) Review Of Data Technical Description By Eeg Technologist Each Increment Of 12-26 Hours; With Continuous Real-Time Monitoring And Maintenance | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 95717 | Electroencephalogram (Eeg) Continuous Recording Physician Or Other Qualified Health Care Professional Review Of Recorded Events Analysis Of Spike And Seizure Detection Interpretation And Report 2-12 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. | _ | _ | _ |
| 95718 | Electroencephalogram (Eeg) Continuous Recording Physician Or Other Qualified Health Care Professional Review Of Recorded Events Analysis Of Spike And Seizure Detection Interpretation And Report 2-12 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. | _ | _ | _ |

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| 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. | _ | _ | _ |

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| 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 | Actigraphy Testing Recording Analysis Interpretation And 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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| 95965 | Magnetoencephalography (Meg) Recording And Analysis; For Spontaneous Brain Magnetic Activity (Eg Epileptic Cerebral Cortex Localization) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 95966 | Magnetoencephalography (Meg) Recording And Analysis; For Evoked Magnetic Fields Single Modality (Eg Sensory Motor Language Or Visual Cortex Localization) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 95967 | Magnetoencephalography (Meg) Recording And Analysis; For Evoked Magnetic Fields Each Additional Modality (Eg Sensory Motor Language Or Visual Cortex Localization) (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. | _ | _ | _ |
| 95980 | Electronic Analysis Of Implanted Neurostimulator Pulse Generator System (Eg Rate Pulse Amplitude And Duration Configuration Of Wave Form Battery Status Electrode Selectability Output Modulation Cycling Impedance And Patient Measurements) Gastric Neurostimulator Pulse Generator/Transmitter; Intraoperative With Programming | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 95981 | Electronic Analysis Of Implanted Neurostimulator Pulse Generator System (Eg Rate Pulse Amplitude And Duration Configuration Of Wave Form Battery Status Electrode Selectability Output Modulation Cycling Impedance And Patient Measurements) Gastric Neurostimulator Pulse Generator/Transmitter; Subsequent Without Reprogramming | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 95982.00 | Electronic Analysis Of Implanted Neurostimulator Pulse Generator System (Eg Rate Pulse Amplitude And Duration Configuration Of Wave Form Battery Status Electrode Selectability Output Modulation Cycling Impedance And Patient Measurements) Gastric Neurostimulator Pulse Generator/Transmitter; Subsequent With Reprogramming | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 95999 | Unlisted Neurological Or Neuromuscular Diagnostic Procedure | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| 96000 | Comprehensive Computer-Based Motion Analysis By Video-Taping And 3D Kinematics; | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 96001 | Comprehensive Computer-Based Motion Analysis By Video-Taping And 3D Kinematics; With Dynamic Plantar Pressure Measurements During Walking | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 96002 | Dynamic Surface Electromyography During Walking Or Other Functional Activities 1-12 Muscles | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 96003 | Dynamic Fine Wire Electromyography During Walking Or Other Functional Activities 1 Muscle | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |

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

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| 96935 | Reflectance Confocal Microscopy (Rcm) For Cellular And Sub-Cellular Imaging Of Skin; Image Acquisition Only Each Additional Lesion (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. | _ | _ | _ |
| 96936 | Reflectance Confocal Microscopy (Rcm) For Cellular And Sub-Cellular Imaging Of Skin; Interpretation And Report Only Each Additional Lesion (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. | _ | _ | _ |
| 96999 | Unlisted Special Dermatological Service Or Procedure | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| 97037 | Application Of A Modality To 1 Or More Areas; Low-Level Laser Therapy (Ie Nonthermal And Non-Ablative) For Post-Operative Pain Reduction | 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 |
| 97039 | Unlisted Modality (Specify Type And Time If Constant Attendance) | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | _ | _ | _ |
| 97139 | Unlisted Therapeutic Procedure (Specify) | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | _ | _ | _ |
| 97169 | 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 The Following: Body Structures Physical Activity And/Or Participation Deficiencies; And Clinical Decision Making Of 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. | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| 97170 | 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 Of 3 Or More Elements From Any Of The Following: Body Structures Physical Activity And/Or Participation 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 | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |

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| 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. | 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 Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | 2/29/2024 | Retire effective 2/29/2024 |

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| 99024 | Postoperative Follow-Up Visit Normally Included In The Surgical Package To Indicate That An Evaluation And Management Service Was Performed During A Postoperative Period For A Reason(S) Related To The Original Procedure | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| 99026 | Hospital Mandated On Call Service; In-Hospital Each Hour | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| 99027 | Hospital Mandated On Call Service; Out-Of-Hospital Each Hour | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| 99050 | Services Provided In The Office At Times Other Than Regularly Scheduled Office Hours Or Days When The Office Is Normally Closed (Eg Holidays Saturday Or Sunday) In Addition To Basic Service | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| 99056 | Service(S) Typically Provided In The Office Provided Out Of The Office At Request Of Patient In Addition To Basic Service | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| 99058 | Service(S) Provided On An Emergency Basis In The Office Which Disrupts Other Scheduled Office Services In Addition To Basic Service | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| 99070 | Supplies And Materials (Except Spectacles) Provided By The Physician Or Other Qualified Health Care Professional Over And Above Those Usually Included With The Office Visit Or Other Services Rendered (List Drugs Trays Supplies Or Materials Provided) | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| 99071 | Educational Supplies Such As Books Tapes And Pamphlets For The Patient'S Education At Cost To Physician Or Other Qualified Health Care Professional | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| 99075 | Medical Testimony | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted or Undefined: Procedures/services not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| 99078 | Physician Or Other Qualified Health Care Professional Qualified By Education Training Licensure/Regulation (When Applicable) Educational Services Rendered To Patients In A Group Setting (Eg Prenatal Obesity Or Diabetic Instructions) | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| 99080 | Special Reports Such As Insurance Forms More Than The Information Conveyed In The Usual Medical Communications Or Standard Reporting Form | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted or Undefined: Procedures/services not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| 99082 | Unusual Travel (Eg Transportation And Escort Of Patient) | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| 99199 | Unlisted Special Service Procedure Or Report | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |

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| 99360 | Standby Service Requiring Prolonged Attendance Each 30 Minutes (Eg Operative Standby Standby For Frozen Section For Cesarean/High Risk Delivery For Monitoring Eeg) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | – | – | – |
| 99429 | Unlisted Preventive Medicine Service | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | – | – | – |
| 99446 | Interprofessional Telephone/Internet/Electronic Health Record Assessment And Management Service Provided By A Consultative Physician Or Other Qualified Health Care Professional Including A Verbal And Written Report To The Patient'S Treating/Requesting Physician Or Other Qualified Health Care Professional; 5-10 Minutes Of Medical Consultative Discussion And Review | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | – | – | – |
| 99447 | Interprofessional Telephone/Internet/Electronic Health Record Assessment And Management Service Provided By A Consultative Physician Or Other Qualified Health Care Professional Including A Verbal And Written Report To The Patient'S Treating/Requesting Physician Or Other Qualified Health Care Professional; 11-20 Minutes Of Medical Consultative Discussion And Review | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | – | – | – |
| 99448 | Interprofessional Telephone/Internet/Electronic Health Record Assessment And Management Service Provided By A Consultative Physician Or Other Qualified Health Care Professional Including A Verbal And Written Report To The Patient'S Treating/Requesting Physician Or Other Qualified Health Care Professional; 21-30 Minutes Of Medical Consultative Discussion And Review | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | – | – | – |
| 99449 | Interprofessional Telephone/Internet/Electronic Health Record Assessment And Management Service Provided By A Consultative Physician Or Other Qualified Health Care Professional Including A Verbal And Written Report To The Patient'S Treating/Requesting Physician Or Other Qualified Health Care Professional; 31 Minutes Or More Of Medical Consultative Discussion And Review | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | – | – | – |
| 99450 | Basic Life And/Or Disability Examination That Includes: Measurement Of Height Weight And Blood Pressure; Completion Of A Medical History Following A Life Insurance Pro Forma; Collection Of Blood Sample And/Or Urinalysis Complying With Chain Of Custody Protocols; And Completion Of Necessary Documentation/Certificates. | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | – | – | – |

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| 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 | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | – | – | – |
| 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 Documentation/Certificates And Report | 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 | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | – | – | – |

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| 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 Per Calendar Month | 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. | _ | _ | _ |
| 0007M | 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. | _ | _ | _ |

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| 0016M | Oncology (Bladder) Mrna Microarray Gene Expression Profiling Of 219 Genes Utilizing Formalin-Fixed Paraffin-Embedded Tissue Algorithm Reported As Molecular Subtype (Luminal Luminal Infiltrated Basal Basal Claudin-Low Neuroendocrine-Like) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 0016U | Oncology (Hematolymphoid Neoplasia) Rna Bcr/Abl1 Major And Minor Breakpoint Fusion Transcripts Quantitative Pcr Amplification Blood Or Bone Marrow Report Of Fusion Not Detected Or Detected With Quantitation | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 0017M | Oncology (Diffuse Large B-Cell Lymphoma [Dlbcl]) Mrna Gene Expression Profiling By Fluorescent Probe Hybridization Of 20 Genes Formalin-Fixed Paraffin-Embedded Tissue Algorithm Reported As Cell Of Origin | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 0017U | Oncology (Hematolymphoid Neoplasia) Jak2 Mutation Dna Pcr Amplification Of Exons 12-14 And Sequence Analysis Blood Or Bone Marrow Report Of Jak2 Mutation Not Detected Or Detected | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 0018U | Oncology (Thyroid) Microrna Profiling By Rt-Pcr Of 10 Microrna Sequences Utilizing Fine Needle Aspirate Algorithm Reported As A Positive Or Negative Result For Moderate To High Risk Of Malignancy | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 0019U | Oncology Rna Gene Expression By Whole Transcriptome Sequencing Formalin-Fixed Paraffin Embedded Tissue Or Fresh Frozen Tissue Predictive Algorithm Reported As Potential Targets For Therapeutic Agents | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 0022U | Targeted Genomic Sequence Analysis Panel Nonsmall Cell Lung Neoplasia Dna And Rna Analysis 23 Genes Interrogation For Sequence Variants And Rearrangements Reported As Presence/-Or Absence Of Variants And Associated Therapy(Ies) To Consider | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 0023U | Oncology (Acute Myelogenous Leukemia) Dna Genotyping Of Internal Tandem Duplication P.D835 P.I836 Using Mononuclear Cells Reported As Detection Or Non-Detection Of Flt3 Mutation And Indication For Or Against The Use Of Midostaurin | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 0026U | Oncology (Thyroid) Dna And Mrna Of 112 Genes Next-Generation Sequencing Fine Needle Aspirate Of Thyroid Nodule Algorithmic Analysis Reported As A Categorical Result (Positive High Probability Of Malignancy Or Negative Low Probability Of Malignancy) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 0027U | Jak2 (Janus Kinase 2) (Eg Myeloproliferative Disorder) Gene Analysis Targeted Sequence Analysis Exons 12-15 | 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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| 0029U | Drug Metabolism (Adverse Drug Reactions And Drug Response) Targeted Sequence Analysis (Ie Cyp1A2 Cyp2C19 Cyp2C9 Cyp2D6 Cyp3A4 Cyp3A5 Cyp4F2 Slco1B1 Vkorc1 And Rs12777823) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 0030U | Drug Metabolism (Warfarin Drug Response) Targeted Sequence Analysis (Ie Cyp2C9 Cyp4F2 Vkorc1 Rs12777823) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 0031U | Cyp1A2 (Cytochrome P450 Family 1 Subfamily A Member 2)(Eg Drug Metabolism) Gene Analysis Common Variants (Ie *1F *1K *6 *7) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 0032U | Comt (Catechol-O-Methyltransferase)(Drug Metabolism) Gene Analysis C.472G>A (Rs4680) Variant | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 0033U | Htr2A (5-Hydroxytryptamine Receptor 2A) Htr2C (5-Hydroxytryptamine Receptor 2C) (Eg Citalopram Metabolism) Gene Analysis Common Variants (Ie Htr2A Rs7997012 [C.614-2211T>C] Htr2C Rs3813929 [C.-759C>T] And Rs1414334 [C.551-3008C>G]) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 0034U | Tpmt (Thiopurine S-Methyltransferase) Nudt15 (Nudix Hydroxylase 15)(Eg Thiopurine Metabolism) Gene Analysis Common Variants (Ie Tpmt *2 *3A *3B *3C *4 *5 *6 *8 *12; Nudt15 *3 *4 *5) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 0036U | Exome (Ie Somatic Mutations) Paired Formalin-Fixed Paraffin-Embedded Tumor Tissue And Normal Specimen Sequence Analyses | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 0037U | Targeted Genomic Sequence Analysis Solid Organ Neoplasm Dna Analysis Of 324 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. | _ | _ | _ |
| 0040U | Bcr/Abl1 (T(9;22)) (Eg Chronic Myelogenous Leukemia) Translocation Analysis Major Breakpoint Quantitative | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 0042T | Cerebral Perfusion Analysis Using Computed Tomography With Contrast Administration Including Post-Processing Of Parametric Maps With Determination Of Cerebral Blood Flow Cerebral Blood Volume And Mean Transit Time | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| 0045U | Oncology (Breast Ductal Carcinoma In Situ) 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 Recurrence Score | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 0046U | Flt3 (Fms-Related Tyrosine Kinase 3) (Eg Acute Myeloid Leukemia) Internal Tandem Duplication (Itd) Variants Quantitative | 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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| 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 | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is 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. | _ | _ | _ |

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

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

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| 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 | Human Papillomavirus (Hpv) High-Risk Types (Ie 16 18 31 33 35 39 45 51 52 56 58 59 66 68) Male Urine | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| 0098T | 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 [Deletion/Duplication Only]) | 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. | _ | _ | _ |

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

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| 0110T | Quantitative Sensory Testing (Qst) Testing And Interpretation Per Extremity; Using Other Stimuli To Assess Sensation | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| 0110U | 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 | Oncology (Colon Cancer) Targeted Kras (Codons 12 13 And 61) And Nras (Codons 12 13 And 61) Gene Analysis Utilizing 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. | _ | _ | _ |

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

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

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| 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). | _ | _ | _ |
| 0200T | 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 |
| 0202T | 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. | _ | _ | _ |

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| 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. | _ | _ | _ |

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

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| 0232T | Injection(S) Platelet Rich Plasma Any Site Including Image Guidance Harvesting And Preparation 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). | _ | _ | _ |
| 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 | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 0233U | Fxn (Frataxin) (Eg Friedreich Ataxia) 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 | 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 | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 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 Insertions Deletions Select Rearrangements And Copy Number Variations | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to 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. | _ | _ | _ |

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| 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. | _ | _ | _ |
| 0263T | 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. | _ | _ | _ |

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

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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 avoid post-service review by Carelon. | _ | _ | _ |
| 0272T | 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): | 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. | _ | _ | _ |

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| 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. | _ | _ | _ |

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| 0314U | Oncology (Cutaneous Melanoma) Mrna Gene Expression Profiling By Rt-Pcr Of 35 Genes (32 Content And 3 Housekeeping) Utilizing Formalin-Fixed Paraffin-Embedded (Ffpe) Tissue Algorithm Reported As A Categorical Result (Ie Benign Intermediate Malignant) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 0315U | Oncology (Cutaneous Squamous Cell Carcinoma) Mrna Gene Expression Profiling By Rt-Pcr Of 40 Genes (34 Content And 6 Housekeeping) Utilizing Formalin-Fixed Paraffin-Embedded (Ffpe) Tissue Algorithm Reported As A Categorical Risk Result (Ie Class 1 Class 2A Class 2B) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 0317U | Oncology (Lung Cancer) Four-Probe Fish (3Q29 3P22.1 10Q22.3 10Cen) Assay Whole Blood Predictive Algorithmgenerated Evaluation Reported As Decreased Or Increased Risk For Lung Cancer | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 0318U | Pediatrics (Congenital Epigenetic Disorders) Whole Genome Methylation Analysis By Microarray For 50 Or More Genes Blood | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 0319U | Nephrology (Renal Transplant) Rna Expression By Select Transcriptome Sequencing Using Pretransplant Peripheral Blood Algorithm Reported As A Risk Score For Early Acute Rejection | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 0320U | Nephrology (Renal Transplant) Rna Expression By Select Transcriptome Sequencing Using Posttransplant Peripheral Blood Algorithm Reported As A Risk Score For Acute Cellular Rejection | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 0322U | Neurology (Autism Spectrum Disorder [Asd]) Quantitative Measurements Of 14 Acyl Carnitines And Microbiome-Derived Metabolites Liquid Chromatography With Tandem Mass Spectrometry (Lc-Ms/Ms) Plasma Results Reported As Negative Or Positive For Risk Of Metabolic Subtypes Associated With Asd | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | 1/14/2024 | Add effective 10/15/2023<br>Retire effective 02/01/2024 |
| 0322U | Neurology (Autism Spectrum Disorder [Asd]) Quantitative Measurements Of 14 Acyl Carnitines And Microbiome-Derived Metabolites Liquid Chromatography With Tandem Mass Spectrometry (Lc-Ms/Ms) Plasma Results Reported As Negative Or Positive For Risk Of Metabolic Subtypes Associated With Asd | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/15/2024 | _ | Add effective 02/01/2024 |
| 0326U | Targeted Genomic Sequence Analysis Panel Solid Organ Neoplasm Cell-Free Circulating Dna Analysis Of 83 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. | _ | _ | _ |
| 0327U | Fetal Aneuploidy (Trisomy 13 18 And 21) Dna Sequence Analysis Of Selected Regions Using Maternal Plasma Algorithm Reported As A Risk Score For Each Trisomy Includes Sex Reporting If Performed | 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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| 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. | _ | _ | _ |
| 0330T | 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. | _ | _ | _ |
| 0332T | 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). | _ | _ | _ |

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| 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. | _ | _ | _ |
| 0338T | Transcatheter Renal Sympathetic Denervation Percutaneous Approach Including Arterial Puncture Selective Catheter Placement(S) Renal Artery(Ies) 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). | _ | _ | _ |
| 0339T | Transcatheter Renal Sympathetic Denervation Percutaneous Approach Including Arterial Puncture Selective Catheter Placement(S) Renal Artery(Ies) 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. | _ | _ | _ |

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| 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(Ies) (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. | _ | _ | _ |
| 0350T | Radiologic Examination Radiostereometric Analysis (Rsa); Lower Extremity(Ies) (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. | _ | _ | _ |
| 0352T | 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. | _ | _ | _ |

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| 0354T | Optical Coherence Tomography Of Breast Surgical Cavity; 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. | _ | _ | _ |
| 0355U | Apol1 (Apolipoprotein L1) (Eg Chronic Kidney Disease) Risk Variants (G1 G2) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 0356U | Oncology (Oropharyngeal Or Anal) Evaluation Of 17 Dna Biomarkers Using Droplet Digital Pcr (Ddpcr) Cell-Free Dna Algorithm Reported As A Prognostic Risk Score For Cancer Recurrence | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 0358T | Bioelectrical Impedance Analysis Whole Body Composition Assessment 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). | _ | _ | _ |
| 0362U | Oncology (Papillary Thyroid Cancer) Gene-Expression Profiling Via Targeted Hybrid Capture– Enrichment Rna Sequencing Of 82 Content Genes And 10 Housekeeping Genes Fine Needle Aspirate Or Formalin-Fixed Paraffinembedded (Ffpe) Tissue Algorithm Reported As One Of Three Molecular Subtypes | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| 0363U | Oncology (Urothelial) Mrna Gene-Expression Profiling By Real-Time Quantitative Pcr Of 5 Genes (Mdk Hoxa13 Cdc2 [Cdk1] Igfbp5 And Cxcr2) Utilizing Urine Algorithm Incorporates Age Sex Smoking History And Macrohematuria Frequency 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. | _ | _ | _ |
| 0364U | Oncology (Hematolymphoid Neoplasm) Genomic Sequence Analysis Using Multiplex (Pcr) And Next-Generation Sequencing With Algorithm Quantification Of Dominant Clonal Sequence(S) Reported As Presence Or Absence Of Minimal Residual Disease (Mrd) With Quantitation Of Disease Burden When Appropriate | 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 |
| 0368U | Oncology (Colorectal Cancer) Evaluation For Mutations Of Apc Braf Ctnnb1 Kras Nras Pik3Ca Smad4 And Tp53 And Methylation Markers (Myo1G Kcnq5 C9Orf50 Fli1 Clip4 Znf132 And Twist1) Multiplex Quantitative Polymerase Chain Reaction (Qpcr) Circulating Cell-Free Dna (Cfdna) Plasma Report Of Risk Score For Advanced Adenoma Or Colorectal Cancer | 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 |
| 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 | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/1/2024 | 5/14/2024 | Add effective 02/01/2024<br>Retire effective 05/14/2024 |

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| 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 |
| 0378T | 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 |
| 0379T | 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. | _ | _ | _ |

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| 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. | _ | _ | _ |
| 0397T | 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). | _ | _ | _ |
| 0398T | 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 |

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| 0409T | Insertion Or Replacement Of Permanent Cardiac Contractility Modulation System Including Contractility Evaluation When Performed And Programming Of Sensing And Therapeutic Parameters; Pulse Generator 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 |
| 0410T | Insertion Or Replacement Of Permanent Cardiac Contractility Modulation System Including Contractility Evaluation When Performed And Programming Of Sensing And Therapeutic Parameters; Atrial Electrode 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 |
| 0411T | Insertion Or Replacement Of Permanent Cardiac Contractility Modulation System Including Contractility Evaluation When Performed And Programming Of Sensing And Therapeutic Parameters; Ventricular Electrode 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 |
| 0412T | Removal Of Permanent Cardiac Contractility Modulation System; Pulse Generator 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 |
| 0413T | Removal Of Permanent Cardiac Contractility Modulation System; Transvenous Electrode (Atrial Or Ventricular) | 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 |
| 0414T | Removal And Replacement Of Permanent Cardiac Contractility Modulation System Pulse Generator 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 |
| 0415T | Repositioning Of Previously Implanted Cardiac Contractility Modulation Transvenous Electrode (Atrial Or Ventricular Lead) | 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 |
| 0416T | Relocation Of Skin Pocket For Implanted Cardiac Contractility Modulation Pulse Generator | 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 |
| 0417T | 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 Including Review And Report Implantable Cardiac Contractility Modulation System | 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 |
| 0418T | Interrogation Device Evaluation (In Person) With Analysis Review And Report Includes Connection Recording And Disconnection Per Patient Encounter Implantable Cardiac Contractility Modulation System | 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 |
| 0422T | Tactile Breast Imaging By Computer-Aided Tactile Sensors Unilateral Or Bilateral | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 0440T | Ablation Percutaneous Cryoablation Includes Imaging Guidance; Upper Extremity Distal/Peripheral Nerve | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/1/2024 | _ | Add effective 05/01/2024 |

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| 0441T | Ablation Percutaneous Cryoablation Includes Imaging Guidance; Lower Extremity Distal/Peripheral Nerve | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/1/2024 | _ | Add effective 05/01/2024 |
| 0442T | Ablation Percutaneous Cryoablation Includes Imaging Guidance; Nerve Plexus Or Other Truncal Nerve (Eg Brachial Plexus Pudendal Nerve) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/1/2024 | _ | Add effective 05/01/2024 |
| 0449T | Insertion Of Aqueous Drainage Device Without Extraocular Reservoir Internal Approach Into The Subconjunctival Space; Initial Device | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 0450T | Insertion Of Aqueous Drainage Device Without Extraocular Reservoir Internal Approach Into The Subconjunctival Space; Each Additional Device (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. | _ | _ | _ |
| 0464T | Visual Evoked Potential Testing For Glaucoma 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). | _ | _ | _ |
| 0472T | Device Evaluation Interrogation And Initial Programming Of Intraocular Retinal Electrode Array (Eg Retinal Prosthesis) In Person With Iterative Adjustment Of The Implantable Device To Test Functionality Select Optimal Permanent Programmed Values With Analysis Including Visual Training With Review And Report By A 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). | _ | _ | _ |
| 0473T | Device Evaluation And Interrogation Of Intraocular Retinal Electrode Array (Eg Retinal Prosthesis) In Person Including Reprogramming And Visual Training When Performed With Review And Report By A 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). | _ | _ | _ |
| 0474T | Insertion Of Anterior Segment Aqueous Drainage Device With Creation Of Intraocular Reservoir Internal Approach Into The Supraciliary Space | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 0479T | Fractional Ablative Laser Fenestration Of Burn And Traumatic Scars For Functional Improvement; First 100 Cm2 Or Part Thereof Or 1% Of Body Surface Area Of Infants And Children | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 0480T | Fractional Ablative Laser Fenestration Of Burn And Traumatic Scars For Functional Improvement; Each Additional 100 Cm2 Or Each Additional 1% Of Body Surface 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. | _ | _ | _ |
| 0483T | Transcatheter Mitral Valve Implantation/Replacement (Tmvi) With Prosthetic Valve; Percutaneous Approach Including Transseptal Puncture When Performed | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 0484T | Transcatheter Mitral Valve Implantation/Replacement (Tmvi) With Prosthetic Valve; Transthoracic Exposure (Eg Thoracotomy Transapical) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |

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

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| 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. | _ | _ | _ |
| 0539T | 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 | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| 0565T | 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. | _ | _ | _ |
| 0570T | 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. | _ | _ | _ |

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| 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 |
| 0587T | 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. | _ | _ | _ |
| 0588T | 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. | _ | _ | _ |
| 0589T | 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. | _ | _ | _ |
| 0590T | 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. | _ | _ | _ |
| 0596T | 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. | _ | _ | _ |

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

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

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

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

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| 0668T | Backbench Standard Preparation Of Cadaver Or Living Donor 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 | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| 0669T | Backbench Reconstruction Of Cadaver Or Living Donor Uterus Allograft Prior To Transplantation; Venous Anastomosis Each | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| 0670T | Backbench Reconstruction Of Cadaver Or Living Donor Uterus Allograft Prior To Transplantation; Arterial Anastomosis Each | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| 0672T | Endovaginal Cryogen-Cooled Monopolar Radiofrequency Remodeling Of The Tissues Surrounding The Female Bladder Neck And Proximal Urethra For Urinary Incontinence | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| 0692T | Therapeutic Ultrafiltration | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/1/2024 | _ | Effective 5/1/2024 |
| 0740T | Remote Autonomous Algorithm-Based Recommendation System For Insulin Dose Calculation And Titration; Initial Set-Up And Patient Education | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 0741T | Remote Autonomous Algorithm-Based Recommendation System For Insulin Dose Calculation And Titration; Provision Of Software Data Collection Transmission And Storage Each 30 Days | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 0743T | 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 | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| 0744T | 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 | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| 0745T | Cardiac Focal Ablation Utilizing Radiation Therapy For Arrhythmia; Noninvasive Arrhythmia Localization And Mapping Of Arrhythmia Site (Nidus) Derived From Anatomical Image Data (Eg Ct Mri Or Myocardial Perfusion Scan) And Electrical Data (Eg 12-Lead Ecg Data) And Identification Of Areas Of Avoidance | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |

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| 0746T | Cardiac Focal Ablation Utilizing Radiation Therapy For Arrhythmia; Conversion Of Arrhythmia Localization And Mapping Of Arrhythmia Site (Nidus) Into A Multidimensional Radiation Treatment Plan | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 0747T | Cardiac Focal Ablation Utilizing Radiation Therapy For Arrhythmia; Delivery Of Radiation Therapy Arrhythmia | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 0748T | Injections Of Stem Cell Product Into Perianal Perifistular Soft Tissue Including Fistula Preparation (Eg Removal Of Setons Fistula Curettage Closure Of Internal Openings) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| 0764T | Assistive Algorithmic Electrocardiogram Risk-Based Assessment For Cardiac Dysfunction (Eg Low-Ejection Fraction Pulmonary Hypertension Hypertrophic Cardiomyopathy); Related To Concurrently Performed Electrocardiogram (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. | _ | _ | _ |
| 0765T | Assistive Algorithmic Electrocardiogram Risk-Based Assessment For Cardiac Dysfunction (Eg Low-Ejection Fraction Pulmonary Hypertension Hypertrophic Cardiomyopathy); Related To Previously Performed Electrocardiogram | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 0766T | Transcutaneous Magnetic Stimulation By Focused Low-Frequency Electromagnetic Pulse Peripheral Nerve With Identification And Marking Of The Treatment Location Including Noninvasive Electroneurographic Localization (Nerve Conduction Localization) When Performed; First 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). | _ | _ | _ |
| 0767T | Transcutaneous Magnetic Stimulation By Focused Low-Frequency Electromagnetic Pulse Peripheral Nerve With Identification And Marking Of The Treatment Location Including Noninvasive Electroneurographic Localization (Nerve Conduction Localization) When Performed; Each Additional Nerve (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). | _ | _ | _ |
| 0770T | Virtual Reality Technology To Assist Therapy (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). | _ | _ | _ |
| 0771T | 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; 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). | _ | _ | _ |

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| 0772T | 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). | _ | _ | _ |
| 0773T | 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). | _ | _ | _ |
| 0774T | 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). | _ | _ | _ |
| 0776T | 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). | _ | _ | _ |
| 0777T | 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). | _ | _ | _ |
| 0779T | 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). | _ | _ | _ |

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| 0782T | Bronchoscopy Rigid Or Flexible With Insertion Of Esophageal Protection Device And Circumferential Radiofrequency Destruction Of The Pulmonary Nerves Including Fluoroscopic Guidance When Performed; Unilateral Mainstem Bronchus | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| 0783T | Transcutaneous Auricular Neurostimulation Set-Up Calibration And Patient Education On Use Of Equipment | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| 0784T | Insertion Or Replacement Of Percutaneous Electrode Array Spinal With Integrated Neurostimulator Including Imaging Guidance When Performed | 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 |
| 0785T | Revision Or Removal Of Neurostimulator Electrode Array Spinal With Integrated Neurostimulator | 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 |
| 0786T | Insertion Or Replacement Of Percutaneous Electrode Array Sacral With Integrated Neurostimulator Including Imaging Guidance When Performed | 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 |
| 0787T | Revision Or Removal Of Neurostimulator Electrode Array Sacral With Integrated Neurostimulator | 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 |
| 0788T | Electronic Analysis With Simple Programming Of Implanted Integrated Neurostimulation System (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 Spinal Cord Or Sacral Nerve 1-3 Parameters | 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 |
| 0789T | 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 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 Spinal Cord Or Sacral Nerve 4 Or More Parameters | 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 |
| 0790T | Revision (Eg Augmentation Division Of Tether) Replacement Or Removal Of Thoracolumbar Or Lumbar Vertebral Body Tethering Including Thoracoscopy 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 |
| 0790T | Revision (Eg Augmentation Division Of Tether) Replacement Or Removal Of Thoracolumbar Or Lumbar Vertebral Body Tethering Including Thoracoscopy 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<br>Retire effective 05/14/2024 |

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

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| 0800T | 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. | _ | _ | _ |
| 0802T | 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. | _ | _ | _ |
| 0803T | 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. | _ | _ | _ |
| 0806T | 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. | _ | _ | _ |

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

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| 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 |
| 0826T | 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. | 4/1/2024 | – | Add effective 04/01/2024 |
| 0862T | 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 |
| 0863T | 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. | – | – | – |

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

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| A2004 | Xcellistem 1 Mg | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| A2005 | Microlyte Matrix Per 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). | _ | _ | _ |
| A2006 | Novosorb Synpath Dermal Matrix Per Square Centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| A2007 | Restrata 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). | _ | _ | _ |
| A2008 | Theragenesis 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). | _ | _ | _ |
| A2009 | Symphony 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). | _ | _ | _ |
| A2010 | Apis Per Square Centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| A2011 | Supra Sdrm Per 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). | _ | _ | _ |
| A2012 | Suprathel 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). | _ | _ | _ |
| A2013 | Innovamatrix Fs 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). | _ | _ | _ |
| A2014 | Omeza Collagen Matrix Per 100 Mg | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| A2015 | Phoenix Wound Matrix Per Square Centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| A2016 | Permeaderm B 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). | _ | _ | _ |
| A2017 | Permeaderm Glove Each | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| A2018 | Permeaderm C 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). | _ | _ | _ |
| A2019 | Kerecis Omega3 Marigen Shield Per Square Centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |

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| A2020 | Ac5 Advanced Wound System (Ac5) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| A2021 | Neomatrix 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). | _ | _ | _ |
| A2022 | Innovaburn Or Innovamatrix Xl 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). | _ | _ | _ |
| A2023 | Innovamatrix Pd 1 Mg | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| A2024 | Resolve Matrix Per Square Centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| A2025 | Miro3D Per Cubic 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). | _ | _ | _ |
| A2026 | Restrata Minimatrix 5 Mg | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2024 | _ | Add effective 04/01/2024 |
| A4100 | Skin Substitute Fda Cleared As A Device 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). | _ | _ | _ |
| A4290 | Sacral Nerve Stimulation Test Lead Each | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| A4335 | Incontinence Supply; Miscellaneous | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| A4341 | Indwelling Intraurethral Drainage Device With Valve Patient Inserted Replacement Only Each | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| A4342 | Accessories For Patient Inserted Indwelling Intraurethral Drainage Device With Valve Replacement Only Each | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| A4421 | Ostomy Supply; Miscellaneous | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| A4458 | Enema Bag With Tubing Reusable | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| 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. | _ | _ | _ |
| A4540 | Distal Transcutaneous Electrical Nerve Stimulator Stimulates Peripheral Nerves Of The Upper Arm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024 | _ | Add effective 05/15/2024 |
| A4540 | Distal Transcutaneous Electrical Nerve Stimulator Stimulates Peripheral Nerves Of The Upper Arm | 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<br>Retire effective 05/14/2024 |

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| A4541 | Monthly Supplies For Use Of Device Coded At E0733 | 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 |
| A4542 | Supplies And Accessories For External Upper Limb Tremor Stimulator Of The Peripheral Nerves Of The Wrist | EIU: Procedure/service not 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 |
| A4542 | Supplies And Accessories For External Upper Limb Tremor Stimulator Of The Peripheral Nerves Of The Wrist | 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<br>Retire effective 05/14/2024 |
| A4553 | Non-Disposable Underpads All Sizes | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| A4554 | Disposable Underpads All Sizes | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| A4555 | Electrode/Transducer For Use With Electrical Stimulation Device Used For Cancer Treatment Replacement Only | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| A4560 | Neuromuscular Electrical Stimulator (Nmes) Disposable Replacement 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). | 1/15/2024 | _ | Add effective 1/15/2024 |
| A4560 | Neuromuscular Electrical Stimulator (Nmes) Disposable Replacement Only | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | 1/14/2024 | Add effective 10/15/2023<br>Retire effective 01/14/2024 |
| A4575 | Topical Hyperbaric Oxygen Chamber Disposable | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| A4596 | Cranial Electrotherapy Stimulation (Ces) System Supplies And Accessories Per Month | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| A4600 | Sleeve For Intermittent Limb Compression Device Replacement Only Each | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| A4638 | Replacement Battery For Patient-Owned Ear Pulse Generator Each | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/1/2024 | _ | Add effective 05/01/2024 |
| A4639 | Replacement Pad For Infrared Heating Pad System Each | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| A4641 | Radiopharmaceutical Diagnostic Not Otherwise Classified | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| A4649 | Surgical Supply; Miscellaneous | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| A4890 | Contracts Repair And Maintenance For Hemodialysis Equipment | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| A4913 | Miscellaneous Dialysis Supplies Not Otherwise Specified | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| A4927 | Gloves Non-Sterile Per 100 | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |

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| 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). | _ | _ | _ |

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| A9291 | Prescription Digital Cognitive And/Or Behavioral Therapy Fda Cleared Per Course 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). | _ | 1/31/2024 | Retire effective 1/31/2024 |
| A9291 | Prescription Digital Cognitive And/Or Behavioral Therapy Fda Cleared Per Course Of Treatment | 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 |
| A9300 | Exercise Equipment | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| A9508 | Iodine I-131 Iobenguane Sulfate Diagnostic Per 0.5 Millicurie | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| A9513 | Lutetium Lu 177 Dotatate Therapeutic 1 Millicurie | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| A9528 | Iodine I-131 Sodium Iodide Capsule(S) Diagnostic Per Millicurie | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| A9531 | Iodine I-131 Sodium Iodide Diagnostic Per Microcurie (Up To 100 Microcuries) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| A9543 | Yttrium Y-90 Ibritumomab Tiuxetan Therapeutic Per Treatment Dose Up To 40 Millicuries | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| A9579 | Injection Gadolinium-Based Magnetic Resonance Contrast Agent Not Otherwise Specified (Nos) Per Ml | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| A9590 | Iodine I-131 Iobenguane 1 Millicurie | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| A9597 | Positron Emission Tomography Radiopharmaceutical Diagnostic For Tumor Identification Not Otherwise Classified | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| A9598 | Positron Emission Tomography Radiopharmaceutical Diagnostic For Non-Tumor Identification Not Otherwise Classified | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| A9600 | Strontium Sr-89 Chloride Therapeutic Per Millicurie | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| A9602 | Fluorodopa F-18 Diagnostic Per Millicurie | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| A9604 | Samarium Sm-153 Lexidronam Therapeutic Per Treatment Dose Up To 150 Millicuries | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| A9606 | Radium Ra-223 Dichloride Therapeutic Per Microcurie | 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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| A9607 | Lutetium Lu 177 Vipivotide Tetraxetan Therapeutic 1 Millicurie | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| A9698 | Non-Radioactive Contrast Imaging Material Not Otherwise Classified Per Study | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| A9699 | Radiopharmaceutical Therapeutic Not Otherwise Classified | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| A9800 | Gallium Ga-68 Gozetotide Diagnostic (Locametz) 1 Millicurie | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| A9900 | Miscellaneous Dme Supply Accessory And/Or Service Component Of Another Hcpcs Code | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| A9999 | Miscellaneous Dme Supply Or Accessory Not Otherwise Specified | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| B9998 | Noc For Enteral Supplies | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| B9999 | Noc For Parenteral Supplies | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| C1052 | Hemostatic Agent Gastrointestinal Topical | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| C1062 | Intravertebral Body Fracture Augmentation With Implant (E.G. Metal Polymer) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2024 | _ | Add effective 04/01/2024 |
| C1761 | Catheter Transluminal Intravascular Lithotripsy Coronary | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| C1764 | Event Recorder Cardiac | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| C1776 | Joint Device (Implantable) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| C1778 | Lead Neurostimulator | 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 |
| C1783 | Ocular Implant Aqueous Drainage Assist Device | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| C1818 | Integrated Keratoprosthesis | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| C1820 | Generator Neurostimulator (Implantable) With Rechargeable Battery And Charging System | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |

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| C1822 | Generator Neurostimulator (Implantable) High Frequency With Rechargeable Battery And Charging System | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| C1823 | Generator Neurostimulator (Implantable) Non-Rechargeable With Transvenous Sensing And Stimulation Leads | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| C1825 | Generator Neurostimulator (Implantable) Non-Rechargeable With Carotid Sinus Baroreceptor Stimulation Lead(S) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| C1826 | Generator Neurostimulator (Implantable) Includes Closed Feedback Loop Leads And All Implantable Components With Rechargeable Battery And Charging System | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| C1827 | Generator Neurostimulator (Implantable) Non-Rechargeable With Implantable Stimulation Lead And External Paired Stimulation Controller | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| C1832 | Autograft Suspension Including Cell Processing And Application And All System Components | EIU: Procedure/service not 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 |
| C1832 | Autograft Suspension Including Cell Processing And Application And All System Components | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/1/2024 | 5/14/2024 | Add effective 02/1/2024<br>Retire effective 05/14/2024 |
| C1833 | Monitor Cardiac Including Intracardiac Lead And All System Components (Implantable) | MP Criteria: Procedure/service reviewed against Medical 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 classified, maybe subject to contract/clinical review. | _ | _ | _ |
| C2623 | Catheter Transluminal Angioplasty Drug-Coated Non-Laser | 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 |
| C2624 | Implantable Wireless Pulmonary Artery Pressure Sensor With Delivery Catheter Including All System Components | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| C2698 | Brachytherapy Source Stranded Not Otherwise Specified Per Source | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| C2699 | Brachytherapy Source Non-Stranded Not Otherwise Specified Per Source | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| C5271 | Application Of Low Cost Skin Substitute Graft To Trunk Arms Legs 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. | _ | _ | _ |
| C5272 | Application Of Low Cost Skin Substitute Graft To Trunk Arms Legs 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. | _ | _ | _ |

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| 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. | _ | _ | _ |

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| C8905 | Magnetic Resonance Imaging Without Contrast Followed By 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. | _ | _ | _ |
| C8906 | Magnetic Resonance Imaging With Contrast Breast; Bilateral | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| C8908 | Magnetic Resonance Imaging Without Contrast Followed By With Contrast Breast; Bilateral | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| C8909 | Magnetic Resonance Angiography With Contrast Chest (Excluding Myocardium) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| C8910 | Magnetic Resonance Angiography Without Contrast Chest (Excluding Myocardium) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| C8911 | Magnetic Resonance Angiography Without Contrast Followed By With Contrast Chest (Excluding Myocardium) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| C8912 | Magnetic Resonance Angiography With Contrast Lower Extremity | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| C8913 | Magnetic Resonance Angiography Without Contrast Lower Extremity | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| C8914 | Magnetic Resonance Angiography Without Contrast Followed By With Contrast Lower Extremity | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| C8918 | Magnetic Resonance Angiography With Contrast Pelvis | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| C8919 | Magnetic Resonance Angiography Without Contrast Pelvis | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| C8920 | Magnetic Resonance Angiography Without Contrast Followed By With Contrast Pelvis | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| C8931 | Magnetic Resonance Angiography With Contrast Spinal Canal And Contents | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| C8932 | Magnetic Resonance Angiography Without Contrast Spinal Canal And Contents | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| C8933 | Magnetic Resonance Angiography Without Contrast Followed By With Contrast Spinal Canal And Contents | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| C8934 | Magnetic Resonance Angiography With Contrast Upper Extremity | 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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| C8935 | Magnetic Resonance Angiography Without Contrast Upper Extremity | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| C8936 | Magnetic Resonance Angiography Without Contrast Followed By With Contrast Upper Extremity | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| C9157 | Injection, tofersen, 1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2023 | _ | Add effective 10/01/2023 |
| C9160 | Injection, daxibotulinumtoxina-lanm, 1 unit | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/15/2024 | _ | Add effective 05/15/2024 |
| C9161 | Injection, aflibercept hd, 1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/1/2024 | _ | Add effective 05/01/2024 |
| C9168 | Injection Mirikizumab-Mrkz 1 Mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/1/2024 | _ | Effective 8/1/2024 |
| C9257 | Injection Bevacizumab 0.25 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. | _ | _ | _ |
| C9354 | Acellular Pericardial Tissue Matrix Of Non-Human Origin (Veritas) 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). | _ | _ | _ |
| C9356 | Tendon Porous Matrix Of Cross-Linked Collagen And Glycosaminoglycan Matrix (Tenoglide Tendon Protector Sheet) 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). | _ | _ | _ |
| C9358 | Dermal Substitute Native Non-Denatured Collagen Fetal Bovine Origin (Surgimend Collagen Matrix) Per 0.5 Square Centimeters | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| C9359 | Porous Purified Collagen Matrix Bone Void Filler (Integra Mozaik Osteoconductive Scaffold Putty Integra Os Osteoconductive Scaffold Putty) Per 0.5 Cc | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| C9360 | Dermal Substitute Native Non-Denatured Collagen Neonatal Bovine Origin (Surgimend Collagen Matrix) Per 0.5 Square Centimeters | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| C9362 | Porous Purified Collagen Matrix Bone Void Filler (Integra Mozaik Osteoconductive Scaffold Strip) Per 0.5 Cc | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| C9363 | Skin Substitute Integra Meshed Bilayer Wound Matrix Per Square Centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| C9364 | Porcine Implant Permacol Per Square Centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |

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| C9399 | Unclassified Drugs Or Biologicals | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | _ | _ | _ |
| C9734 | Focused Ultrasound Ablation/Therapeutic Intervention Other Than Uterine Leiomyomata With Magnetic Resonance (Mr) Guidance | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| C9739 | Cystourethroscopy With Insertion Of Transprostatic Implant; 1 To 3 Implants | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| C9740 | Cystourethroscopy With Insertion Of Transprostatic Implant; 4 Or More Implants | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| C9757 | 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 | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| C9764 | Revascularization Endovascular Open Or Percutaneous Any Vessel(S); With Intravascular Lithotripsy Includes Angioplasty Within The Same Vessel(S) When Performed | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| C9765 | 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 | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| C9766 | Revascularization Endovascular Open Or Percutaneous Any Vessel(S); With Intravascular Lithotripsy And Atherectomy Includes Angioplasty Within The Same Vessel(S) When Performed | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| C9767 | 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 | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| C9768 | Endoscopic Ultrasound-Guided Direct Measurement Of Hepatic Portosystemic Pressure Gradient By Any Method (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). | _ | _ | _ |
| C9769 | Cystourethroscopy With Insertion Of Temporary Prostatic Implant/Stent With Fixation/Anchor And Incisional Struts | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| C9772 | Revascularization Endovascular Open Or Percutaneous Tibial/Peroneal Artery(Ies) With Intravascular Lithotripsy Includes Angioplasty Within The Same Vessel (S) 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). | _ | _ | _ |

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

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| C9796 | Repair Of Enterocutaneous Fistula Small Intestine Or Colon (Excluding Anorectal Fistula) With Plug (E.G. Porcine Small Intestine Submucosa [Sis]) | 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<br>Retire effective 06/30/2024 |
| C9796 | Repair Of Enterocutaneous Fistula Small Intestine Or Colon (Excluding Anorectal Fistula) With Plug (E.G. Porcine Small Intestine Submucosa [Sis]) | EIU: Procedure/service not 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 |
| C9898 | Radiolabeled Product Provided During A Hospital Inpatient Stay | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | – | – | – |
| C9899 | Implanted Prosthetic Device Payable Only For Inpatients Who Do Not Have Inpatient Coverage | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | – | – | – |
| D0999 | Unspecified Diagnostic Procedure By Report | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | – | – | – |
| D1705 | Astrazeneca Covid-19 Vaccine Administration – First Dose | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | – | – | – |
| D1706 | Astrazeneca Covid-19 Vaccine Administration – Second Dose | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | – | – | – |
| D1999 | Unspecified Preventive Procedure By Report | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | – | – | – |
| D2999 | Unspecified Restorative Procedure By Report | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | – | – | – |
| D3410 | Apicoectomy - Anterior | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | – | – | – |
| D3999 | Unspecified Endodontic Procedure By Report | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | – | – | – |
| D4999 | Unspecified Periodontal Procedure By Report | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | – | – | – |
| D5899 | Unspecified Removable Prosthodontic Procedure By Report | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | – | – | – |
| D5999 | Unspecified Maxillofacial Prosthesis By Report | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | – | – | – |
| D6199 | Unspecified Implant Procedure By Report | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | – | – | – |
| D6999 | Unspecified Fixed Prosthodontic Procedure By Report | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | – | – | – |
| D7210 | Extraction Erupted Tooth Requiring Removal Of Bone And/Or Sectioning Of Tooth And Including Elevation Of Mucoperiosteal Flap If Indicated | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | – | – | – |
| D7220 | Removal Of Impacted Tooth - Soft Tissue | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | – | – | – |
| D7230 | Removal Of Impacted Tooth - Partially Bony | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | – | – | – |
| D7999 | Unspecified Oral Surgery Procedure By Report | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | – | – | – |
| D8210 | Removable Appliance Therapy | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | – | – | – |

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| D8220 | Fixed Appliance Therapy | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| D8999 | Unspecified Orthodontic Procedure By Report | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| D9999 | Unspecified Adjunctive Procedure By Report | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| E0183 | Powered Pressure Reducing Underlay/Pad Alternating With Pump Includes Heavy Duty | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| E0210 | Electric Heat Pad Standard | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| E0217 | Water 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. | _ | _ | _ |
| E0221 | Infrared Heating Pad System | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| E0231 | Non-Contact Wound Warming Device (Temperature Control Unit Ac Adapter And Power Cord) For Use With Warming Card And Wound Cover | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| E0232 | Warming Card For Use With The Non Contact Wound Warming Device And Non Contact Wound Warming Wound Cover | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| E0236 | Pump For Water Circulating Pad | Non Covered: Procedure/service not covered by the Plan. 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. Not subject to pre-service review. | _ | _ | _ |
| E0241 | Bath Tub Wall Rail Each | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| E0242 | Bath Tub Rail Floor Base | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| E0243 | Toilet Rail Each | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| E0244 | Raised Toilet Seat | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| E0245 | Tub Stool Or Bench | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| E0246 | Transfer Tub Rail Attachment | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| E0247 | Transfer Bench For Tub Or Toilet With Or Without Commode Opening | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| E0248 | Transfer Bench Heavy Duty For Tub Or Toilet With Or Without Commode Opening | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| E0273 | Bed Board | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |

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

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

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| E0667 | Segmental Pneumatic Appliance For Use With Pneumatic Compressor Full Leg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| E0668 | Segmental Pneumatic Appliance For Use With Pneumatic Compressor Full Arm | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| E0669 | Segmental Pneumatic Appliance For Use With Pneumatic Compressor Half Leg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| E0670 | Segmental Pneumatic Appliance For Use With Pneumatic Compressor Integrated 2 Full Legs And Trunk | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| E0671 | Segmental Gradient Pressure Pneumatic Appliance Full Leg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| E0672 | Segmental Gradient Pressure Pneumatic Appliance Full Arm | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| E0673 | Segmental Gradient Pressure Pneumatic Appliance Half Leg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| E0675 | Pneumatic Compression Device High Pressure Rapid Inflation/Deflation Cycle For Arterial Insufficiency (Unilateral Or Bilateral System) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| E0676 | Intermittent Limb Compression Device (Includes All Accessories) Not Otherwise Specified | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.<br>Unlisted or Undefined: Procedures/services not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| E0677 | Non-Pneumatic Sequential Compression Garment Trunk | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| E0678 | Non-Pneumatic Sequential Compression Garment Full Leg | 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 |
| E0679 | Non-Pneumatic Sequential Compression Garment Half Leg | 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 |
| E0680 | Non-Pneumatic Compression Controller With Sequential Calibrated Gradient Pressure | 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 |
| E0681 | Non-Pneumatic Compression Controller Without Calibrated Gradient Pressure | 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 |

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

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

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

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| E1008 | Wheelchair Accessory Power Seating System Combination Tilt And Recline With Power Shear Reduction | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| E1009 | Wheelchair Accessory Addition To Power Seating System Mechanically Linked Leg Elevation System Including Pushrod And Leg Rest Each | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| E1010 | Wheelchair Accessory Addition To Power Seating System Power Leg Elevation System Including Leg Rest Pair | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| E1012 | Wheelchair Accessory Addition To Power Seating System Center Mount Power Elevating Leg Rest/Platform Complete System Any Type Each | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| E1161 | Manual Adult Size Wheelchair Includes Tilt In Space | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| E1229 | Wheelchair Pediatric Size Not Otherwise Specified | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| E1230 | Power Operated Vehicle (Three Or Four Wheel Nonhighway) Specify Brand Name And Model Number | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| E1239 | Power Wheelchair Pediatric Size Not Otherwise Specified | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.<br>Unlisted or Undefined: Procedures/services not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| E1301 | Whirlpool Tub Walk-In Portable | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 4/24/2024 | _ | Effective 4/24/2024 |
| E1399 | Durable Medical Equipment Miscellaneous | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| E1629 | Tablo Hemodialysis System For The Billable Dialysis Service | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| E1632 | Wearable Artificial Kidney Each | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| E1699 | Dialysis Equipment Not Otherwise Specified | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| E1700 | Jaw Motion Rehabilitation System | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| E1701 | Replacement Cushions For Jaw Motion Rehabilitation System Pkg. Of 6 | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| E1702 | Replacement Measuring Scales For Jaw Motion Rehabilitation System Pkg. Of 200 | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |

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

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

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| E2375 | Power Wheelchair Accessory Non-Expandable Controller Including All Related Electronics And Mounting Hardware Replacement Only | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| E2376 | Power Wheelchair Accessory Expandable Controller Including All Related Electronics And Mounting Hardware Replacement Only | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| E2377 | Power Wheelchair Accessory Expandable Controller Including All Related Electronics And Mounting Hardware Upgrade Provided At Initial Issue | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| E2500 | Speech Generating Device Digitized Speech Using Pre-Recorded Messages Less Than Or Equal To 8 Minutes Recording Time | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| E2502 | Speech Generating Device Digitized Speech Using Pre-Recorded Messages Greater Than 8 Minutes But Less Than Or Equal To 20 Minutes Recording Time | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| E2504 | Speech Generating Device Digitized Speech Using Pre-Recorded Messages Greater Than 20 Minutes But Less Than Or Equal To 40 Minutes Recording Time | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| E2506 | Speech Generating Device Digitized Speech Using Pre-Recorded Messages Greater Than 40 Minutes Recording Time | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| E2508 | Speech Generating Device Synthesized Speech Requiring Message Formulation By Spelling And Access By Physical Contact With The Device | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| E2510 | Speech Generating Device Synthesized Speech Permitting Multiple Methods Of Message Formulation And Multiple Methods Of Device Access | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| E2511 | Speech Generating Software Program For Personal Computer Or Personal Digital Assistant | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| E2512 | Accessory For Speech Generating Device Mounting System | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| E2599 | Accessory For Speech Generating Device Not Otherwise Classified | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.<br>Unlisted or Undefined: Procedures/services not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| E2610 | Wheelchair Seat Cushion Powered | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| E3000 | Speech Volume Modulation System Any Type Including All Components And Accessories | EIU: Procedure/service not 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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| 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<br>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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| G0294 | Noncovered Procedure(S) Using Either No Anesthesia Or Local Anesthesia Only In A Medicare Qualifying Clinical Trial Per Day | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| G0295 | Electromagnetic Therapy To One Or More Areas For Wound Care Other Than Described In G0329 Or For Other Uses | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| G0329 | Electromagnetic Therapy To One Or More Areas For Chronic Stage Iii And Stage Iv Pressure Ulcers Arterial Ulcers Diabetic Ulcers And Venous Stasis 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). | _ | _ | _ |
| G0339 | Image-Guided Robotic Linear Accelerator-Based Stereotactic Radiosurgery Complete Course Of Therapy In One Session Or First Session Of Fractionated Treatment | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| G0340 | Image-Guided Robotic Linear Accelerator-Based Stereotactic Radiosurgery Delivery Including Collimator Changes And Custom Plugging Fractionated Treatment All Lesions Per Session Second Through Fifth Sessions Maximum Five Sessions Per Course Of Treatment | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| G0341 | Percutaneous Islet Cell Transplant Includes Portal Vein Catheterization And Infusion | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| G0342 | Laparoscopy For Islet Cell Transplant Includes Portal Vein Catheterization And Infusion | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| G0343 | Laparotomy For Islet Cell Transplant Includes Portal Vein Catheterization And Infusion | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| G0422 | Intensive Cardiac Rehabilitation; With Or Without Continuous Ecg Monitoring With Exercise Per Session | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| G0423 | Intensive Cardiac Rehabilitation; With Or Without Continuous Ecg Monitoring; Without Exercise Per Session | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| G0428 | Collagen Meniscus Implant Procedure For Filling Meniscal Defects (E.G. Cmi Collagen Scaffold Menaflex) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| G0429 | Dermal Filler Injection(S) For The Treatment Of Facial Lipodystrophy Syndrome (Lds) (E.G. As A Result Of Highly Active Antiretroviral Therapy.) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| G0458 | Low Dose Rate (Ldr) Prostate Brachytherapy Services Composite Rate | 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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| G0460 | Autologous Platelet Rich Plasma Or Other Blood-Derived Product For Non-Diabetic Chronic Wounds/Ulcers Including As Applicable Phlebotomy Centrifugation Or Mixing And All Other Preparatory Procedures Administration And Dressings Per 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). | _ | _ | _ |
| G0465 | Autologous Platelet Rich Plasma (Prp) Or Other Blood-Derived Product For Diabetic Chronic Wounds/Ulcers Using An Fda-Cleared Device For This Indication (Includes As Applicable Administration Dressings Phlebotomy Centrifugation Or Mixing And All Other Preparatory Procedures Per 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). | _ | _ | _ |
| G2011 | Alcohol And/Or Substance (Other Than Tobacco) Misuse Structured Assessment (E.G. Audit Dast) And Brief Intervention 5-14 Minutes | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| G2082 | 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 Professional And Provision Of Up To 56 Mg Of Esketamine Nasal Self-Administration Includes 2 Hours Post-Administration Observation | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| G2083 | 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 Professional And Provision Of Greater Than 56 Mg Esketamine Nasal Self-Administration Includes 2 Hours Post-Administration Observation | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| G6001 | Ultrasonic Guidance For Placement Of Radiation Therapy Fields | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| G6002 | Stereoscopic X-Ray Guidance For Localization Of Target Volume For The Delivery Of Radiation Therapy | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| G6003 | Radiation Treatment Delivery Single Treatment Area Single Port Or Parallel Opposed Ports Simple Blocks Or No Blocks: Up To 5Mev | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| G6004 | Radiation Treatment Delivery Single Treatment Area Single Port Or Parallel Opposed Ports Simple Blocks Or No Blocks: 6-10Mev | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| G6005 | Radiation Treatment Delivery Single Treatment Area Single Port Or Parallel Opposed Ports Simple Blocks Or No Blocks: 11-19Mev | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| G6006 | Radiation Treatment Delivery Single Treatment Area Single Port Or Parallel Opposed Ports Simple Blocks Or No Blocks: 20Mev Or Greater | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| G6007 | Radiation Treatment Delivery 2 Separate Treatment Areas 3 Or More Ports On A Single Treatment Area Use Of Multiple Blocks: Up To 5Mev | 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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| G6008 | Radiation Treatment Delivery 2 Separate Treatment Areas 3 Or More Ports On A Single Treatment Area Use Of Multiple Blocks: 6-10Mev | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| G6009 | Radiation Treatment Delivery 2 Separate Treatment Areas 3 Or More Ports On A Single Treatment Area Use Of Multiple Blocks: 11-19Mev | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| G6010 | Radiation Treatment Delivery 2 Separate Treatment Areas 3 Or More Ports On A Single Treatment Area Use Of Multiple Blocks: 20 Mev Or Greater | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| G6011 | Radiation Treatment Delivery 3 Or More Separate Treatment Areas Custom Blocking Tangential Ports Wedges Rotational Beam Compensators Electron Beam; Up To 5Mev | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| G6012 | Radiation Treatment Delivery 3 Or More Separate Treatment Areas Custom Blocking Tangential Ports Wedges Rotational Beam Compensators Electron Beam; 6-10Mev | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| G6013 | Radiation Treatment Delivery 3 Or More Separate Treatment Areas Custom Blocking Tangential Ports Wedges Rotational Beam Compensators Electron Beam; 11-19Mev | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| G6014 | Radiation Treatment Delivery 3 Or More Separate Treatment Areas Custom Blocking Tangential Ports Wedges Rotational Beam Compensators Electron Beam; 20Mev Or Greater | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| G6015 | Intensity Modulated Treatment Delivery Single Or Multiple Fields/Arcs Via Narrow Spatially And Temporally Modulated Beams Binary Dynamic Mlc Per Treatment Session | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| G6016 | Compensator-Based Beam Modulation Treatment Delivery Of Inverse Planned Treatment Using 3 Or More High Resolution (Milled Or Cast) Compensator Convergent Beam Modulated Fields Per Treatment Session | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| G6017 | Intra-Fraction Localization And Tracking Of Target Or Patient Motion During Delivery Of Radiation Therapy (Eg 3D Positional Tracking Gating 3D Surface Tracking) Each Fraction Of Treatment | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| G8395 | Left Ventricular Ejection Fraction (Lvef) >= 40% Or Documentation As Normal Or | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| G8396 | Left Ventricular Ejection Fraction (Lvef) Not Performed Or Documented | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| G8397 | Dilated Macular Or Fundus Exam Performed Including Documentation Of The | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| G8399 | Patient With Documented Results Of A Central Dual-Energy X-Ray Absorptiometry (Dxa) Ever Being Performed | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |

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

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

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

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| 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. | – | – | – |

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| G9071 | 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/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. | – | – | – |
| 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. | – | – | – |

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| G9079 | Oncology; Disease Status; Prostate Cancer Limited To Adenocarcinoma As Predominant Cell Type; T3B-T4 Any N; Any T N1 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. | – | – | – |
| G9080 | Oncology; Disease Status; Prostate Cancer Limited To Adenocarcinoma; After Initial Treatment With Rising Psa Or Failure Of Psa Decline (For Use In A Medicare-Approved Demonstration Project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | – | – | – |
| G9083 | Oncology; Disease Status; Prostate Cancer Limited To Adenocarcinoma; 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. | – | – | – |
| G9084 | Oncology; Disease Status; Colon Cancer Limited To Invasive Cancer Adenocarcinoma As Predominant Cell Type; Extent Of Disease Initially Established As T1-3 N0 M0 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. | – | – | – |
| G9085 | Oncology; Disease Status; Colon Cancer Limited To Invasive Cancer Adenocarcinoma As Predominant Cell Type; Extent Of Disease Initially Established As T4 N0 M0 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. | – | – | – |
| G9086 | 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 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. | – | – | – |
| G9087 | Oncology; Disease Status; Colon Cancer Limited To Invasive Cancer Adenocarcinoma As Predominant Cell Type; M1 At Diagnosis Metastatic Locally Recurrent Or Progressive With Current Clinical Radiologic Or Biochemical Evidence Of Disease (For Use In A Medicare-Approved Demonstration Project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | – | – | – |
| G9088 | Oncology; Disease Status; Colon Cancer Limited To Invasive 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 Demonstration Project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | – | – | – |

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| 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 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. | – | – | – |
| 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. | – | – | – |

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| 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 R0 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 M0 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. | – | – | – |

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| G9104 | Oncology; Disease Status; Gastric Cancer Limited To 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. | – | – | – |
| G9105 | Oncology; Disease Status; Pancreatic Cancer Limited To Adenocarcinoma As Predominant Cell Type; Post R0 Resection 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. | – | – | – |
| G9106 | Oncology; Disease Status; Pancreatic Cancer Limited To Adenocarcinoma; Post R1 Or R2 Resection 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. | – | – | – |
| G9107 | Oncology; Disease Status; Pancreatic Cancer Limited To Adenocarcinoma; Unresectable At Diagnosis 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. | – | – | – |
| G9108 | Oncology; Disease Status; Pancreatic Cancer Limited To Adenocarcinoma; 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. | – | – | – |
| G9109 | 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 Established As T1-T2 And 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. | – | – | – |
| G9110 | 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 Established As T3-4 And/Or N1-3 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. | – | – | – |
| G9111 | Oncology; Disease Status; Head And Neck Cancer Limited To Cancers Of Oral Cavity Pharynx And Larynx With Squamous Cell 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. | – | – | – |
| G9112 | 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 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. | – | – | – |

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| 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. | – | – | – |

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

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| 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 avoid post-service review by Carelon. | _ | _ | _ |
| G9147 | Outpatient Intravenous Insulin Treatment (Oivit) Either Pulsatile Or Continuous By Any Means Guided By The Results Of Measurements For:Respiratory Quotient; And/Or Urine Urea Nitrogen (Uun); And/Or Arterial Venous Or Capillary Glucose; And/Or Potassium Concentration | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| G9978 | Remote 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. | _ | _ | _ |

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| G9979 | 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: An Expanded Problem Focused History;An Expanded Problem Focused Examination;Straightforward Medical Decision Making Furnished In Real Time Using Interactive Audio And Video Technology. Counseling And Coordination Of Care With Other Physicians Other Qualified Health Care Professionals Or Agencies Are Provided Consistent With The Nature Of The Problem(S) And The Needs Of The Patient Or The Family Or Both. Usually The Presenting Problem(S) Are Of Low To Moderate Severity. Typically 20 Minutes Are Spent With The Patient Or Family Or Both Via Real Time Audio And Video Intercommunications Technology. | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | – | – | – |
| G9980 | 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 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. | – | – | – |

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| G9981 | 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 Moderate Complexity Furnished In Real Time Using Interactive Audio And Video Technology.Counseling And Coordination Of Care With Other Physicians Other Qualified Health Care Professionals Or Agencies Are Provided Consistent With The Nature Of The Problem(S) And The Needs Of The Patient Or The Family Or Both. Usually The Presenting Problem(S) Are Of Moderate To High Severity. Typically 45 Minutes Are Spent With The Patient Or Family Or Both Via Real Time Audio And Video Intercommunications Technology. | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | – | – | – |
| G9982 | 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 Audio And Video Technology.Counseling And Coordination Of Care With Other Physicians Other Qualified Health Care Professionals Or Agencies Are Provided Consistent With The Nature Of The Problem(S) And The Needs Of The Patient Or The Family Or Both. Usually The Presenting Problem(S) Are Of Moderate To High Severity. Typically 60 Minutes Are Spent With The Patient Or Family Or Both Via Real Time Audio And Video Intercommunications Technology. | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | – | – | – |

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| G9983 | 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 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. | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | – | – | – |
| G9984 | 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 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. | – | – | – |

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| G9985 | 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 Advanced (Bpci Advanced) Model Episode Of Care Which Requires At Least 2 Of The Following 3 Key Components:A Detailed History; A Detailed Examination;Medical Decision Making Of Moderate Complexity Furnished In Real Time Using Interactive Audio And Video Technology.Counseling And Coordination Of Care With Other Physicians Other Qualified Health Care Professionals Or Agencies Are Provided Consistent With The Nature Of The Problem(S) And The Needs Of The Patient Or The Family Or Both. Usually The Presenting Problem(S) Are Of Moderate To High Severity. Typically 25 Minutes Are Spent With The Patient Or Family Or Both Via Real Time Audio And Video Intercommunications Technology. | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | – | – | – |
| G9986 | 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 Advanced (Bpci Advanced) Model Episode Of Care Which Requires At Least 2 Of The Following 3 Key Components:A Comprehensive History;A Comprehensive Examination;Medical Decision Making Of High Complexity Furnished In Real Time Using Interactive Audio And Video Technology.Counseling And Coordination Of Care With Other Physicians Other Qualified Health Care Professionals Or Agencies Are Provided Consistent With The Nature Of The Problem(S) And The Needs Of The Patient Or The Family Or Both. Usually The Presenting Problem(S) Are Of Moderate To High Severity. Typically 40 Minutes Are Spent With The Patient Or Family Or Both Via Real Time Audio And Video Intercommunications Technology. | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | – | – | – |
| G9987 | Bundled Payments For Care Improvement Advanced (Bpci Advanced) Model Home Visit For Patient Assessment Performed By Clinical Staff For An Individual Not Considered Homebound Including But Not Necessarily Limited To Patient Assessment Of Clinical Status Safety/Fall Prevention Functional Status/Ambulation Medication Reconciliation/Management Compliance With Orders/Plan Of Care Performance Of Activities Of Daily Living And Ensuring Beneficiary Connections To Community And Other Services; For Use Only For A Bpci Advanced Model Episode Of Care; May Not Be Billed For A 30-Day Period Covered By A Transitional Care Management Code. | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | – | – | – |

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

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| J0223 | Injection Givosiran 0.5 Mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | – | – | – |
| J0224 | Injection Lumasiran 0.5 Mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | – | – | – |
| J0225 | Injection Vutrisiran 1 Mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | – | – | – |
| J0248 | Injection Remdesivir 1Mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/1/2024 | – | Add effective 05/01/2024 |
| J0256 | Injection Alpha 1 Proteinase Inhibitor (Human) Not Otherwise Specified 10 Mg | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | – | – | – |
| J0485 | Injection Belatacept 1 Mg | 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 |
| J0490 | Injection Belimumab 10 Mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | – | – | – |
| J0491 | Injection Anifrolumab-Fnia 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. | – | – | – |
| J0517 | Injection Benralizumab 1 Mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | – | – | – |
| J0565 | Injection Bezlotoxumab 10 Mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | – | – | – |
| J0567 | Injection Cerliponase Alfa 1 Mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | – | – | – |
| J0584 | Injection Burosumab-Twza 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. | – | – | – |
| J0586 | Injection Abobotulinumtoxina 5 Units | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | – | – | – |

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| J0587 | Injection Rimabotulinumtoxinb 100 Units | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | _ | _ | _ |
| J0588 | Injection Incobotulinumtoxin A 1 Unit | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | _ | _ | _ |
| J0589 | Injection Daxibotulinumtoxina-Lanm 1 Unit | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/15/2024 | _ | Add effective 05/15/2024 |
| J0717 | Injection Certolizumab Pegol 1 Mg (Code May Be Used For Medicare When Drug Administered Under The Direct Supervision Of A Physician Not For Use When Drug Is Self Administered) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | _ | _ | _ |
| J0739 | Injection, cabotegravir, 1mg, fda approved prescription, only for use as hiv pre-exposure prophylaxis (not for use as treatment for hiv) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | 3/14/2024 | retire effective 03/14/2024 |
| J0741 | Injection Cabotegravir And Rilpivirine 2Mg/3Mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| J0775 | Injection Collagenase Clostridium Histolyticum 0.01 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. | _ | _ | _ |
| J0791 | Injection Crizanlizumab-Tmca 5 Mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | _ | _ | _ |
| J0881 | Injection Darbepoetin Alfa 1 Microgram (Non-Esrd Use) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | _ | _ | _ |
| J1203 | Injection Cipaglucosidase Alfa-Atga 5 Mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/15/2024 | _ | Add effective 07/15/2024 |
| J1301 | Injection Edaravone 1 Mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | _ | _ | _ |
| 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. | _ | _ | _ |
| J1302 | Injection Sutimlimab-Jome 10 Mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |

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| J1303 | Injection Ravulizumab-Cwvz 10 Mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | _ | _ | _ |
| J1304 | Injection Tofersen 1 Mg | 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 |
| J1305 | Injection Evinacumab-Dgnb 5Mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | _ | _ | _ |
| J1306 | Injection Inclisiran 1 Mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | _ | _ | _ |
| J1325 | Injection Epoprostenol 0. 5 Mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | _ | _ | _ |
| J1411 | Injection Etranacogene Dezaparvovec-Drlb Per Therapeutic Dose | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| J1412 | Injection Valoctocogene Roxaparvovec-Rvox Per Ml Containing Nominal 2 X 10^13 Vector Genomes | 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 |
| J1413 | Injection Delandistrogene Moxeparvovec-Rokl Per Therapeutic Dose | 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 |
| J1426 | Injection Casimersen 10 Mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| J1427 | Injection Viltolarsen 10 Mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| J1428 | Injection Eteplirsen 10 Mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | _ | _ | _ |
| J1429 | Injection Golodirsen 10 Mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| J1551 | Injection Immune Globulin (Cutaquig) 100 Mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | _ | _ | _ |

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

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| J2182 | Injection Mepolizumab 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. | _ | _ | _ |
| J2278 | Injection Ziconotide 1 Microgram | 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. | _ | 5/31/2024 | Retire effective 5/31/2024 |
| J2327 | Injection Risankizumab-Rzaa Intravenous 1 Mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| J2329 | Injection Ublituximab-Xiiy 1Mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| J2353 | Injection Octreotide Depot Form For Intramuscular Injection 1 Mg | 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 |
| J2354 | Injection Octreotide Non-Depot Form For Subcutaneous Or Intravenous Injection 25 Mcg | 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 |
| J2356 | Injection Tezepelumab-Ekko 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. | _ | _ | _ |
| J2440 | Injection Papaverine Hcl Up To 60 Mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| J2502 | Injection Pasireotide Long Acting 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. | _ | 4/30/2024 | Retire effective 4/30/2024 |
| J2508 | Injection Pegunigalsidase Alfa-Iwxj 1 Mg | 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 |
| J2777 | Injection Faricimab-Svoa 0.1 Mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| J2778 | Injection Ranibizumab 0.1 Mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| J2779 | Injection Ranibizumab Via Intravitreal Implant (Susvimo) 0.1 Mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| J2782 | Injection Avacincaptad Pegol 0.1 Mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/15/2024 | _ | Add effective 07/15/2024 |

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| J2796 | Injection Romiplostim 10 Micrograms | 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 |
| J3032 | Injection Eptinezumab-Jjmr 1 Mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | _ | _ | _ |
| J3111 | Injection Romosozumab-Aqqg 1 Mg | 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 |
| 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. | _ | _ | _ |
| 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. | _ | _ | _ |
| J3241 | Injection Teprotumumab-Trbw 10 Mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | _ | _ | _ |
| J3245 | Injection Tildrakizumab 1 Mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | _ | 5/31/2024 | Retire effective 5/31/2024 |
| J3285 | Injection Treprostinil 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. | _ | _ | _ |
| J3299 | Injection Triamcinolone Acetonide (Xipere) 1 Mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| J3380 | Injection Vedolizumab Intravenous 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. | _ | _ | _ |
| J3396 | Injection Verteporfin 0.1 Mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| J3398 | Injection Voretigene Neparvovec-Rzyl 1 Billion Vector Genomes | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | _ | _ | _ |

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| J3399 | Injection Onasemnogene Abeparvovec-Xioi Per Treatment Up To 5X10^15 Vector Genomes | 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. | _ | _ | _ |
| J3401 | Beremagene Geperpavec-Svdt For Topical Administration Containing Nominal 5 X 10^9 Pfu/Ml Vector Genomes Per 0.1 Ml | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2024 | _ | Add effective 02/15/2024 |
| J3490 | Unclassified Drugs | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | _ | _ | _ |
| J3520 | Edetate Disodium Per 150 Mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| J3570 | Laetrile Amygdalin Vitamin B17 | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| J3590 | Unclassified Biologics | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | _ | _ | _ |
| J3591 | Unclassified Drug Or Biological Used For Esrd On Dialysis | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| J7177 | Injection Human Fibrinogen Concentrate (Fibryga) 1 Mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| J7178 | Injection Human Fibrinogen Concentrate Not Otherwise Specified 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. | _ | _ | _ |
| J7183 | Injection Von Willebrand Factor Complex (Human) Wilate 1 I.U. Vwf:Rco | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2024 | _ | Add effective 04/01/2024 |
| J7192 | Factor Viii (Antihemophilic Factor Recombinant) Per I.U. Not Otherwise Specified | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| J7195 | Injection Factor Ix (Antihemophilic Factor Recombinant) Per Iu Not Otherwise Specified | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| J7199 | Hemophilia Clotting Factor Not Otherwise Classified | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| J7309 | Methyl Aminolevulinate (Mal) For Topical Administration 16.8% 1 Gram | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| J7316 | Injection Ocriplasmin 0.125 Mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| J7330 | Autologous Cultured Chondrocytes Implant | 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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| J7402 | Mometasone Furoate Sinus Implant (Sinuva) 10 Micrograms | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| J7599 | Immunosuppressive Drug Not Otherwise Classified | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| J7604 | Acetylcysteine Inhalation Solution Compounded Product Administered Through | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| J7607 | Levalbuterol Inhalation Solution Compounded Product Administered Through Dme Concentrated Form 0.5 Mg | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| J7609 | Albuterol Inhalation Solution Compounded Product Administered Through Dme Unit Dose 1 Mg | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| J7610 | Albuterol Inhalation Solution Compounded Product Administered Through Dme Concentrated Form 1 Mg | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| J7615 | Levalbuterol Inhalation Solution Compounded Product Administered Through Dme Unit Dose 0.5 Mg | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| J7622 | Beclomethasone Inhalation Solution Compounded Product Administered Through Dme Unit Dose Form Per Milligram | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| J7624 | Betamethasone Inhalation Solution Compounded Product Administered Through Dme Unit Dose Form Per Milligram | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| J7627 | Budesonide Inhalation Solution Compounded Product Administered Through Dme Unit Dose Form Up To 0.5 Mg | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| J7628 | Bitolterol Mesylate Inhalation Solution Compounded Product Administered Through Dme Concentrated Form Per Milligram | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| J7629 | Bitolterol Mesylate Inhalation Solution Compounded Product Administered Through Dme Unit Dose Form Per Milligram | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| J7632 | Cromolyn Sodium Inhalation Solution Compounded Product Administered Through | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| J7634 | Budesonide Inhalation Solution Compounded Product Administered Through Dme Concentrated Form Per 0.25 Milligram | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| J7635 | Atropine Inhalation Solution Compounded Product Administered Through Dme Concentrated Form Per Milligram | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| J7636 | Atropine Inhalation Solution Compounded Product Administered Through Dme Unit Dose Form Per Milligram | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |

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

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

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| J9345 | Injection Retifanlimab-Dlwr 1 Mg | 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 |
| J9350 | Injection Mosunetuzumab-Axgb 1 Mg | 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 |
| J9376 | Injection Pozelimab-Bbfg 1 Mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/15/2024 | _ | Add effective 04/01/2024 |
| J9381 | Injection Teplizumab-Mzwv 5 Mcg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| J9600 | Injection Porfimer Sodium 75 Mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| J9999 | Not Otherwise Classified Antineoplastic Drugs | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | _ | _ | _ |
| K0005 | Ultralightweight Wheelchair | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| K0010 | Standard - Weight Frame Motorized/Power Wheelchair | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| K0011 | Standard - Weight Frame Motorized/Power Wheelchair With Programmable Control Parameters For Speed Adjustment Tremor Dampening Acceleration Control And Braking | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| K0012 | Lightweight Portable Motorized/Power Wheelchair | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| K0013 | Custom Motorized/Power Wheelchair Base | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| K0014 | Other Motorized/Power Wheelchair Base | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| K0053 | Elevating Footrests Articulating (Telescoping) Each | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| K0065 | Spoke Protectors Each | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |

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| K0108 | Wheelchair Component Or Accessory Not Otherwise Specified | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.<br>Unlisted or Undefined: Procedures/services not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| K0455 | Infusion Pump Used For Uninterrupted Parenteral Administration Of Medication (E. G. Epoprostenol Or Treprostinol) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| K0800 | Power Operated Vehicle Group 1 Standard Patient Weight Capacity Up To And Including 300 Pounds | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| K0801 | Power Operated Vehicle Group 1 Heavy Duty Patient Weight Capacity 301 To 450 Pounds | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| K0802 | Power Operated Vehicle Group 1 Very Heavy Duty Patient Weight Capacity 451 To 600 Pounds | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| K0806 | Power Operated Vehicle Group 2 Standard Patient Weight Capacity Up To And Including 300 Pounds | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| K0807 | Power Operated Vehicle Group 2 Heavy Duty Patient Weight Capacity 301 To 450 Pounds | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| K0808 | Power Operated Vehicle Group 2 Very Heavy Duty Patient Weight Capacity 451 To 600 Pounds | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| K0812 | Power Operated Vehicle Not Otherwise Classified | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.<br>Unlisted or Undefined: Procedures/services not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| K0813 | Power Wheelchair Group 1 Standard Portable Sling/Solid Seat And Back Patient Weight Capacity Up To And Including 300 Pounds | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| K0814 | Power Wheelchair Group 1 Standard Portable Captains Chair Patient Weight Capacity Up To And Including 300 Pounds | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| K0815 | Power Wheelchair Group 1 Standard Sling/Solid Seat And Back Patient Weight Capacity Up To And Including 300 Pounds | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| K0816 | Power Wheelchair Group 1 Standard Captains Chair Patient Weight Capactiy Up To And Including 300 Pounds | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |

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| K0820 | Power Wheelchair Group 2 Standard Portable Sling/Solid Seat/Back Patient Weight Capacity Up To And Including 300 Pounds | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| K0821 | Power Wheelchair Group 2 Standard Portable Captains Chair Patient Weight Capacity Up To And Including 300 Pounds | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| K0822 | Power Wheelchair Group 2 Standard Sling/Solid Seat/Back Patient Weight Capacity Up To And Including 300 Pounds | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| K0823 | Power Wheelchair Group 2 Standard Captains Chair Patient Weight Capacity Up To And Including 300 Pounds | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| K0824 | Power Wheelchair Group 2 Heavy Duty Sling/Solid Seat/Back Patient Weight Capacity 301 To 450 Pounds | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| K0825 | Power Wheelchair Group 2 Heavy Duty Captains Chair Patient Weight Capacity 301 To 450 Pounds | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| K0826 | Power Wheelchair Group 2 Very Heavy Duty Sling/Solid Seat/Back Patient Weight Capacity 451 To 600 Pounds | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| K0827 | Power Wheelchair Group 2 Very Heavy Duty Captains Chair Patient Weight Capacity 451 To 600 Pounds | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| K0828 | Power Wheelchair Group 2 Extra Heavy Duty Sling/Solid Seat/Back Patient Weight Capacity 601 Pounds Or More | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| K0829 | Power Wheelchair Group 2 Extra Heavy Duty Captains Chair Patient Weight Capacity 601 Pounds Or More | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| K0830 | Power Wheelchair Group 2 Standard Seat Elevator Sling/Solid Seat/Back Patient Weight Capacity Up To And Including 300 Pounds | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| K0831 | Power Wheelchair Group 2 Standard Seat Elevator Captains Chair Patient Weight Capacity Up To And Including 300 Pounds | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| K0835 | Power Wheelchair Group 2 Standard Single Power Option Sling/Solid Seat/Back Patient Weight Capacity Up To And Including 300 Pounds | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| K0836 | Power Wheelchair Group 2 Standard Single Power Option Captains Chair Patient Weight Capacity Up To And Including 300 Pounds | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| K0837 | Power Wheelchair Group 2 Heavy Duty Single Power Option Sling/Solid Seat/Back Patient Weight Capacity 301 To 450 Pounds | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| K0838 | Power Wheelchair Group 2 Heavy Duty Single Power Option Captains Chair Patient Weight Capacity 301 To 450 Pounds | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |

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| K0839 | Power Wheelchair Group 2 Very Heavy Duty Single Power Option Sling/Solid Seat/Back Patient Weight Capacity 451 To 600 Pounds | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| K0840 | Power Wheelchair Group 2 Extra Heavy Duty Single Power Option Sling/Solid Seat/Back Patient Weight Capacity 601 Pounds Or More | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| K0841 | Power Wheelchair Group 2 Standard Multiple Power Option Sling/Solid Seat/Back Patient Weight Capacity Up To And Including 300 Pounds | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| K0842 | Power Wheelchair Group 2 Standard Multiple Power Option Captains Chair Patient Weight Capacity Up To And Including 300 Pounds | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| K0843 | Power Wheelchair Group 2 Heavy Duty Multiple Power Option Sling/Solid Seat/Back Patient Weight Capacity 301 To 450 Pounds | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| K0848 | Power Wheelchair Group 3 Standard Sling/Solid Seat/Back Patient Weight Capacity Up To And Including 300 Pounds | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| K0849 | Power Wheelchair Group 3 Standard Captains Chair Patient Weight Capacity Up To And Including 300 Pounds | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| K0850 | Power Wheelchair Group 3 Heavy Duty Sling/Solid Seat/Back Patient Weight Capacity 301 To 450 Pounds | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| K0851 | Power Wheelchair Group 3 Heavy Duty Captains Chair Patient Weight Capacity 301 To 450 Pounds | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| K0852 | Power Wheelchair Group 3 Very Heavy Duty Sling/Solid Seat/Back Patient Weight Capacity 451 To 600 Pounds | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| K0853 | Power Wheelchair Group 3 Very Heavy Duty Captains Chair Patient Weight Capacity 451 To 600 Pounds | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| K0854 | Power Wheelchair Group 3 Extra Heavy Duty Sling/Solid Seat/Back Patient Weight Capacity 601 Pounds Or More | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| K0855 | Power Wheelchair Group 3 Extra Heavy Duty Captains Chair Patient Weight Capacity 601 Pounds Or More | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| K0856 | Power Wheelchair Group 3 Standard Single Power Option Sling/Solid Seat/Back Patient Weight Capacity Up To And Including 300 Pounds | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| K0857 | Power Wheelchair Group 3 Standard Single Power Option Captains Chair Patient Weight Capacity Up To And Including 300 Pounds | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| K0858 | Power Wheelchair Group 3 Heavy Duty Single Power Option Sling/Solid Seat/Back Patient Weight Capacity 301 To 450 Pounds | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |

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| K0859 | Power Wheelchair Group 3 Heavy Duty Single Power Option Captains Chair Patient Weight Capacity 301 To 450 Pounds | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| K0860 | Power Wheelchair Group 3 Very Heavy Duty Single Power Option Sling/Solid Seat/Back Patient Weight Capacity 451 To 600 Pounds | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| K0861 | Power Wheelchair Group 3 Standard Multiple Power Option Sling/Solid Seat/Back Patient Weight Capacity Up To And Including 300 Pounds | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| K0862 | Power Wheelchair Group 3 Heavy Duty Multiple Power Option Sling/Solid Seat/Back Patient Weight Capacity 301 To 450 Pounds | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| K0863 | Power Wheelchair Group 3 Very Heavy Duty Multiple Power Option Sling/Solid Seat/Back Patient Weight Capacity 451 To 600 Pounds | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| K0864 | Power Wheelchair Group 3 Extra Heavy Duty Multiple Power Option Sling/Solid Seat/Back Patient Weight Capacity 601 Pounds Or More | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| K0868 | Power Wheelchair Group 4 Standard Sling/Solid Seat/Back Patient Weight Capacity Up To And Including 300 Pounds | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| K0869 | Power Wheelchair Group 4 Standard Captains Chair Patient Weight Capacity Up To And Including 300 Pounds | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| K0870 | Power Wheelchair Group 4 Heavy Duty Sling/Solid Seat/Back Patient Weight Capacity 301 To 450 Pounds | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| K0871 | Power Wheelchair Group 4 Very Heavy Duty Sling/Solid Seat/Back Patient Weight Capacity 451 To 600 Pounds | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| K0877 | Power Wheelchair Group 4 Standard Single Power Option Sling/Solid Seat/Back Patient Weight Capacity Up To And Including 300 Pounds | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| K0878 | Power Wheelchair Group 4 Standard Single Power Option Captains Chair Patient Weight Capacity Up To And Including 300 Pounds | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| K0879 | Power Wheelchair Group 4 Heavy Duty Single Power Option Sling/Solid Seat/Back Patient Weight Capacity 301 To 450 Pounds | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| K0880 | Power Wheelchair Group 4 Very Heavy Duty Single Power Option Sling/Solid Seat/Back Patient Weight 451 To 600 Pounds | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| K0884 | Power Wheelchair Group 4 Standard Multiple Power Option Sling/Solid Seat/Back Patient Weight Capacity Up To And Including 300 Pounds | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| K0885 | Power Wheelchair Group 4 Standard Multiple Power Option Captains Chair Weight Capacity Up To And Including 300 Pounds | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |

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| K0886 | Power Wheelchair Group 4 Heavy Duty Multiple Power Option Sling/Solid Seat/Back Patient Weight Capacity 301 To 450 Pounds | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| K0890 | Power Wheelchair Group 5 Pediatric Single Power Option Sling/Solid Seat/Back Patient Weight Capacity Up To And Including 125 Pounds | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| K0891 | Power Wheelchair Group 5 Pediatric Multiple Power Option Sling/Solid Seat/Back Patient Weight Capacity Up To And Including 125 Pounds | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| K0898 | Power Wheelchair Not Otherwise Classified | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| K0899 | Power Mobile Device; No Dme Pdac | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| K1004 | Low Frequency Ultrasonic Diathermy Treatment Device For Home Use | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| K1007 | Bilateral Hip Knee Ankle Foot Device Powered Includes Pelvic Component Single Or Double Upright(S) Knee Joints Any Type With Or Without Ankle Joints Any Type Includes All Components And Accessories Motors Microprocessors Sensors | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| K1016 | Transcutaneous electrical nerve stimulator for electrical stimulation of the trigeminal nerve | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/15/2023 | _ | Add effective 10/15/2023 |
| K1017 | Monthly supplies for use of device coded at k1016 | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/15/2023 | _ | Add effective 10/15/2023 |
| K1027 | Oral Device/Appliance Used To Reduce Upper Airway Collapsibility Without Fixed Mechanical Hinge Custom Fabricated Includes Fitting And Adjustment | 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. | _ | _ | _ |
| K1030 | External Recharging System For Battery (Internal) For Use With Implanted Cardiac Contractility Modulation Generator Replacement Only | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| K1036 | Supplies And Accessories (E.G. Transducer) For Low Frequency Ultrasonic Diathermy Treatment Device Per Month | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| L0999 | Addition To Spinal Orthosis Not Otherwise Specified | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| L1320 | Thoracic Pectus Carinatum Orthosis Sternal Compression Rigid Circumferential Frame With Anterior And Posterior Rigid Pads Custom Fabricated | 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 |
| L1499 | Spinal Orthosis Not Otherwise Specified | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |

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

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| 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. | _ | _ | _ |

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| L6975 | Interscapular-Thoracic 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. | _ | _ | _ |
| L7008 | Electric Hand Switch Or Myoelectric Controlled Pediatric | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| L7009 | Electric Hook Switch Or Myoelectric Controlled Adult | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| L7040 | Prehensile Actuator Switch Controlled | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| L7045 | Electric Hook Switch Or Myoelectric Ontrolled Pediatric | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| L7170 | Electronic Elbow Hosmer Or Equal Switch Controlled | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| L7180 | Electronic Elbow Microprocessor Sequential Control Of Elbow And Terminal Device | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| L7181 | Electronic Elbow Microprocessor Simultaneous Control Of Elbow And Terminal Device | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| L7185 | Electronic Elbow Adolescent Variety Village Or Equal Switch Controlled | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| L7186 | Electronic Elbow Child Variety Village Or Equal Switch Controlled | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| L7190 | Electronic Elbow Adolescent Variety Village Or Equal Myoelectronically Controlled | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| L7191 | Electronic Elbow Child Variety Village Or Equal Myoelectronically Controlled | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| L7364 | Twelve Volt Battery Each | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| L7366 | Battery Charger Twelve Volt Each | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| L7499 | Upper Extremity Prosthesis Not Otherwise Specified | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |

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

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| L8619 | Cochlear Implant External Speech Processor And Controller Integrated System Replacement | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | _ | _ | _ |
| L8621 | Zinc Air Battery For Use With Cochlear Implant Device And Auditory Osseointegrated Sound Processors Replacement Each | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | _ | _ | _ |
| L8622 | Alkaline Battery For Use With Cochlear Implant Device Any Size Replacement Each | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | _ | _ | _ |
| L8623 | Lithium Ion Battery For Use With Cochlear Implant Device Speech Processor Other Than Ear Level Replacement Each | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | _ | _ | _ |
| L8624 | Lithium Ion Battery For Use With Cochlear Implant Or Auditory Osseointegrated Device Speech Processor Ear Level Replacement Each | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | _ | _ | _ |
| L8627 | Cochlear Implant External Speech Processor Component Replacement | 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. | _ | _ | _ |
| L8628 | Cochlear Implant External Controller Component Replacement | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | _ | _ | _ |
| L8629 | Transmitting Coil And Cable Integrated For Use With Cochlear Implant Device Replacement | 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. | _ | _ | _ |
| L8678 | Electrical Stimulator Supplies (External) For Use With Implantable Neurostimulator Per Month | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| L8679 | Implantable Neurostimulator Pulse Generator Any Type | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| L8680 | Implantable Neurostimulator Electrode Each | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| L8681 | Patient Programmer (External) For Use With Implantable Programmable Neurostimulator Pulse Generator Replacement Only | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| L8682 | Implantable Neurostimulator Radiofrequency Receiver | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |

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

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| M0076 | Prolotherapy | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| M0240 | Intravenous Infusion Or Subcutaneous Injection Casirivimab And Imdevimab Includes Infusion Or Injection And Post Administration Monitoring Subsequent Repeat Doses | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| M0241 | Intravenous Infusion Or Subcutaneous Injection Casirivimab And Imdevimab Includes Infusion Or Injection And Post Administration Monitoring In The Home Or Residence This Includes A Beneficiary'S Home That Has Been Made Provider-Based To The Hospital During The Covid-19 Public Health Emergency Subsequent Repeat Doses | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| M0243 | Intravenous Infusion Or Subcutaneous Injection Casirivimab And Imdevimab Includes Infusion Or Injection And Post Administration Monitoring | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| M0244 | Intravenous Infusion Or Subcutaneous Injection Casirivimab And Imdevimab Includes Infusion Or Injection And Post Administration Monitoring In The Home Or Residence; This Includes A Beneficiary'S Home That Has Been Made Provider-Based To The Hospital During The Covid-19 Public Health Emergency | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| M0245 | Intravenous Infusion Bamlanivimab And Etesevimab Includes Infusion And Post Administration Monitoring | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| M0246 | Intravenous Infusion Bamlanivimab And Etesevimab Includes Infusion And Post Administration Monitoring In The Home Or Residence; This Includes A Beneficiary'S Home That Has Been Made Provider Based To The Hospital During The Covid 19 Public Health Emergency | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| P2031 | Hair Analysis (Excluding Arsenic) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| P9020 | Platelet Rich Plasma Each Unit | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| P9099 | Blood Component Or Product Not Otherwise Classified | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.<br>Unlisted or Undefined: Procedures/services not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| Q0240 | Injection Casirivimab And Imdevimab 600 Mg | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |

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| Q0243 | Injection Casirivimab And Imdevimab 2400 Mg | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| Q0244 | Injection Casirivimab And Imdevimab 1200 Mg | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| Q0245 | Injection Bamlanivimab And Etesevimab 2100 Mg | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| Q0507 | Miscellaneous Supply Or Accessory For Use With An External Ventricular Assist Device | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| Q0508 | Miscellaneous Supply Or Accessory For Use With An Implanted Ventricular Assist Device | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| Q0509 | Miscellaneous Supply Or Accessory For Use With Any Implanted Ventricular Assist Device For Which Payment Was Not Made Under Medicare Part A | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| Q0510 | Pharmacy Supply Fee For Initial Immunosuppressive Drug(S) First Month Following Transplant | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| Q0511 | Pharmacy Supply Fee For Oral Anti-Cancer Oral Anti-Emetic Or Immunosuppressive Drug(S); For The First Prescription In A 30-Day Period | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| Q0512 | Pharmacy Supply Fee For Oral Anti-Cancer Oral Anti-Emetic Or Immunosuppressive Drug(S); For A Subsequent Prescription In A 30-Day Period | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| Q2026 | Injection Radiesse 0.1 Ml | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| Q2028 | Injection Sculptra 0.5 Mg | MP Criteria: Procedure/service reviewed against Medical 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. | _ | _ | _ |
| Q2041 | Axicabtagene Ciloleucel Up To 200 Million Autologous Anti-Cd19 Car Positive Viable T Cells Including Leukapheresis And Dose Preparation Procedures Per Therapeutic Dose | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | _ | _ | _ |
| Q2042 | Tisagenlecleucel Up To 600 Million Car-Positive Viable T Cells Including Leukapheresis And Dose Preparation Procedures Per Therapeutic Dose | 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. | _ | _ | _ |
| Q2049 | Injection Doxorubicin Hydrochloride Liposomal Imported Lipodox 10 Mg | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 4/1/2024 | _ | Add effective 04/01/2024 |
| Q2050 | Injection Doxorubicin Hydrochloride Liposomal Not Otherwise Specified 10Mg | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | _ | _ | _ |

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

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| Q4104 | Integra Bilayer Matrix Wound Dressing (Bmwd) 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). | _ | _ | _ |
| Q4105 | Integra Dermal Regeneration Template (Drt) Or Integra Omnigraft Dermal Regeneration Matrix Per Square Centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| Q4106 | Dermagraft Per Square Centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| Q4107 | Graftjacket Per Square Centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| Q4108 | Integra Matrix Per Square Centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| Q4110 | Primatrix 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). | _ | _ | _ |
| Q4111 | Gammagraft 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). | _ | _ | _ |
| Q4112 | Cymetra Injectable 1Cc | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| Q4113 | Graftjacket Xpress Injectable 1Cc | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| Q4114 | Integra Flowable Wound Matrix Injectable 1Cc | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| Q4115 | Alloskin 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). | _ | _ | _ |
| Q4116 | Alloderm Per Square Centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| Q4117 | Hyalomatrix 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). | _ | _ | _ |
| Q4118 | Matristem Micromatrix 1 Mg | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| Q4121 | Theraskin 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). | _ | _ | _ |
| Q4122 | Dermacell Dermacell Awm Or Dermacell Awm Porous Per Square Centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |

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| Q4123 | Alloskin Rt Per Square Centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| Q4124 | Oasis Ultra Tri-Layer Wound Matrix Per Square Centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| Q4125 | Arthroflex Per Square Centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| Q4126 | Memoderm Dermaspan Tranzgraft Or Integuply 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). | _ | _ | _ |
| Q4127 | Talymed Per Square Centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| Q4128 | Flex Hd Or Allopatch Hd Per Square Centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| Q4130 | Strattice Tm Per Square Centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| Q4132 | Grafix Core And Grafixpl Core Per Square Centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| Q4133 | Grafix Prime Grafixpl Prime Stravix And Stravixpl Per Square Centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| Q4134 | Hmatrix 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). | _ | _ | _ |
| Q4135 | Mediskin 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). | _ | _ | _ |
| Q4136 | Ez-Derm 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). | _ | _ | _ |
| Q4137 | Amnioexcel Amnioexcel Plus Or Biodexcel 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). | _ | _ | _ |
| Q4138 | Biodfence Dryflex 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). | _ | _ | _ |
| Q4139 | Amniomatrix Or Biodmatrix Injectable 1 Cc | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| Q4140 | Biodfence Per Square Centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |

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

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| Q4158 | Kerecis Omega3 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). | _ | _ | _ |
| Q4159 | Affinity Per Square Centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| Q4160 | Nushield 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). | _ | _ | _ |
| Q4161 | Bio-Connekt Wound Matrix Per Square Centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| Q4162 | Woundex Flow Bioskin Flow 0.5 Cc | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| Q4163 | Woundex Bioskin 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). | _ | _ | _ |
| Q4164 | Helicoll 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). | _ | _ | _ |
| Q4165 | Keramatrix Or Kerasorb 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). | _ | _ | _ |
| Q4166 | Cytal Per Square Centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| Q4167 | Truskin Per 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). | _ | _ | _ |
| Q4168 | Amnioband 1 Mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| Q4169 | Artacent Wound Per 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). | _ | _ | _ |
| Q4170 | Cygnus 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). | _ | _ | _ |
| Q4171 | Interfyl 1 Mg | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| Q4173 | Palingen Or Palingen Xplus 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). | _ | _ | _ |
| Q4174 | Palingen Or Promatrx 0.36 Mg Per 0.25 Cc | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |

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| Q4175 | Miroderm 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). | _ | _ | _ |
| Q4176 | Neopatch Or Therion Per Square Centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| Q4177 | Floweramnioflo 0.1 Cc | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| Q4178 | Floweramniopatch Per 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). | _ | _ | _ |
| Q4179 | Flowerderm 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). | _ | _ | _ |
| Q4180 | Revita 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). | _ | _ | _ |
| Q4181 | Amnio Wound 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). | _ | _ | _ |
| Q4182 | Transcyte 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). | _ | _ | _ |
| Q4183 | Surgigraft 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). | _ | _ | _ |
| Q4184 | Cellesta Or Cellesta Duo 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). | _ | _ | _ |
| Q4185 | Cellesta Flowable Amnion (25 Mg Per Cc); Per 0.5 Cc | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| Q4186 | Epifix Per Square Centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| Q4187 | Epicord Per Square Centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| Q4188 | Amnioarmor 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). | _ | _ | _ |
| Q4189 | Artacent Ac 1 Mg | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| Q4190 | Artacent Ac Per Square Centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |

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| Q4191 | Restorigin 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). | _ | _ | _ |
| Q4192 | Restorigin 1 Cc | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| Q4193 | Coll-E-Derm 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). | _ | _ | _ |
| Q4194 | Novachor 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). | _ | _ | _ |
| Q4195 | Puraply 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). | _ | _ | _ |
| Q4196 | Puraply Am 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). | _ | _ | _ |
| Q4197 | Puraply Xt 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). | _ | _ | _ |
| Q4198 | Genesis Amniotic Membrane 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). | _ | _ | _ |
| Q4199 | Cygnus Matrix Per Square Centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| Q4200 | Skin Te 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). | _ | _ | _ |
| Q4201 | Matrion 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). | _ | _ | _ |
| Q4202 | Keroxx (2.5G/Cc) 1Cc | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| Q4203 | Derma-Gide 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). | _ | _ | _ |
| Q4204 | Xwrap 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). | _ | _ | _ |
| Q4205 | Membrane Graft Or Membrane Wrap 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). | _ | _ | _ |
| Q4206 | Fluid Flow Or Fluid Gf 1 Cc | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |

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| Q4208 | Novafix Per Square Cenitmeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| Q4209 | Surgraft Per 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). | _ | _ | _ |
| Q4210 | Axolotl Graft Or Axolotl Dualgraft 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). | _ | _ | _ |
| Q4211 | Amnion Bio Or Axobiomembrane 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). | _ | _ | _ |
| Q4212 | Allogen Per Cc | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| Q4213 | Ascent 0.5 Mg | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| Q4214 | Cellesta Cord Per 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). | _ | _ | _ |
| Q4215 | Axolotl Ambient Or Axolotl Cryo 0.1 Mg | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| Q4216 | Artacent Cord Per 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). | _ | _ | _ |
| Q4217 | Woundfix Biowound Woundfix Plus Biowound Plus Woundfix Xplus Or Biowound Xplus 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). | _ | _ | _ |
| Q4218 | Surgicord 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). | _ | _ | _ |
| Q4219 | Surgigraft-Dual 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). | _ | _ | _ |
| Q4220 | Bellacell Hd Or Surederm 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). | _ | _ | _ |
| Q4221 | Amniowrap2 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). | _ | _ | _ |
| Q4222 | Progenamatrix 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). | _ | _ | _ |
| Q4224 | Human Health Factor 10 Amniotic Patch (Hhf10-P) Per Square Centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |

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| Q4225 | Amniobind Or Dermabind Tl 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). | _ | _ | _ |
| Q4227 | Amniocore 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). | _ | _ | _ |
| Q4229 | Cogenex Amniotic Membrane 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). | _ | _ | _ |
| Q4230 | Cogenex Flowable Amnion Per 0.5 Cc | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| Q4231 | Corplex P Per Cc | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| Q4232 | Corplex Per 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). | _ | _ | _ |
| Q4233 | Surfactor Or Nudyn Per 0.5 Cc | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| Q4234 | Xcellerate Per 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). | _ | _ | _ |
| Q4235 | Amniorepair Or Altiply 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). | _ | _ | _ |
| Q4236 | Carepatch 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). | _ | _ | _ |
| Q4237 | Cryo-Cord 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). | _ | _ | _ |
| Q4238 | Derm-Maxx 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). | _ | _ | _ |
| Q4239 | Amnio-Maxx Or Amnio-Maxx Lite 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). | _ | _ | _ |
| Q4240 | Corecyte For Topical Use Only Per 0.5 Cc | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| Q4241 | Polycyte For Topical Use Only Per 0.5 Cc | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| Q4242 | Amniocyte Plus Per 0.5 Cc | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |

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| Q4244 | Procenta, per 200 mg | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | _ | _ |
| Q4245 | Amniotext Per Cc | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| Q4246 | Coretext Or Protext Per Cc | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| Q4247 | Amniotext Patch Per 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). | _ | _ | _ |
| Q4248 | Dermacyte Amniotic Membrane Allograft 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). | _ | _ | _ |
| Q4249 | Amniply For Topical Use Only 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). | _ | _ | _ |
| Q4250 | Amnioamp-Mp 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). | _ | _ | _ |
| Q4251 | Vim Per Square Centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| Q4252 | Vendaje Per Square 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). | _ | _ | _ |
| Q4253 | Zenith Amniotic Membrane 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). | _ | _ | _ |
| Q4254 | Novafix Dl 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). | _ | _ | _ |
| Q4255 | Reguard For Topical Use Only 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). | _ | _ | _ |
| Q4256 | Mlg-Complete 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). | _ | _ | _ |
| Q4257 | Relese 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). | _ | _ | _ |
| Q4258 | Enverse 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). | _ | _ | _ |
| Q4259 | Celera Dual Layer Or Celera Dual Membrane Per Square Centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |

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| Q4260 | Signature Apatch 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). | _ | _ | _ |
| Q4261 | Tag Per Square Centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| Q4262 | Dual Layer Impax Membrane 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). | _ | _ | _ |
| Q4263 | Surgraft Tl 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). | _ | _ | _ |
| Q4264 | Cocoon Membrane 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). | _ | _ | _ |
| Q4265 | Neostim Tl 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). | _ | _ | _ |
| Q4266 | Neostim Membrane 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). | _ | _ | _ |
| Q4267 | Neostim Dl 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). | _ | _ | _ |
| Q4268 | Surgraft Ft 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). | _ | _ | _ |
| Q4269 | Surgraft Xt 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). | _ | _ | _ |
| Q4270 | Complete Sl 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). | _ | _ | _ |
| Q4271 | Complete Ft 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). | _ | _ | _ |
| Q4272 | Esano A 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). | _ | _ | _ |
| Q4273 | Esano Aaa 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). | _ | _ | _ |
| Q4274 | Esano Ac 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). | _ | _ | _ |
| Q4275 | Esano Aca Per Square Centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |

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| Q4276 | Orion 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). | _ | _ | _ |
| Q4277 | Woundplus Membrane Or E-Graft 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). | _ | _ | _ |
| Q4278 | Epieffect 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). | _ | _ | _ |
| Q4279 | Vendaje Ac Per Square Centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024 | 6/30/2024 | Add effective 03/15/2024<br>Retire effecitve 06/30/2024 |
| Q4279 | Vendaje Ac 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). | 7/1/2024 | _ | Add effective 07/01/2024 |
| Q4280 | Xcell Amnio Matrix Per Square Centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| Q4281 | Barrera Sl Or Barrera Dl 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). | _ | _ | _ |
| Q4282 | Cygnus Dual 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). | _ | _ | _ |
| Q4283 | Biovance Tri-Layer Or Biovance 3L Per Square Centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| Q4284 | Dermabind Sl 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). | _ | _ | _ |
| Q4285 | Nudyn Dl Or Nudyn Dl Mesh 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). | _ | _ | _ |
| Q4286 | Nudyn Sl Or Nudyn Slw 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). | _ | _ | _ |
| Q4287 | Dermabind Dl Per Square Centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024 | 6/30/2024 | Add effective 03/15/2024<br>Retire effecitve 06/30/2024 |
| Q4287 | Dermabind Dl 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). | 7/1/2024 | _ | Add effective 07/01/2024 |
| Q4288 | Dermabind Ch Per Square Centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024 | 6/30/2024 | Add effective 03/15/2024<br>Retire effecitve 06/30/2024 |
| Q4288 | Dermabind Ch 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). | 7/1/2024 | _ | Add effective 07/01/2024 |

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| Q4289 | Revoshield + Amniotic Barrier Per Square Centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024 | 6/30/2024 | Add effective 03/15/2024<br>Retire effecitve 06/30/2024 |
| Q4289 | Revoshield + Amniotic Barrier 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). | 7/1/2024 | _ | Add effective 07/01/2024 |
| Q4290 | Membrane Wrap-Hydro Per Square Centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024 | 6/30/2024 | Add effective 03/15/2024<br>Retire effecitve 06/30/2024 |
| Q4290 | Membrane Wrap-Hydro 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). | 7/1/2024 | _ | Add effective 07/01/2024 |
| Q4291 | Lamellas Xt Per Square Centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024 | 6/30/2024 | Add effective 03/15/2024<br>Retire effecitve 06/30/2024 |
| Q4291 | Lamellas Xt 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). | 7/1/2024 | _ | Add effective 07/01/2024 |
| Q4292 | Lamellas Per Square Centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024 | 6/30/2024 | Add effective 03/15/2024<br>Retire effecitve 06/30/2024 |
| Q4292 | Lamellas 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). | 7/1/2024 | _ | Add effective 07/01/2024 |
| Q4293 | Acesso Dl Per Square Centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024 | 6/30/2024 | Add effective 03/15/2024<br>Retire effecitve 06/30/2024 |
| Q4293 | Acesso Dl 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). | 7/1/2024 | _ | Add effective 07/01/2024 |
| Q4294 | Amnio Quad-Core Per Square Centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024 | 6/30/2024 | Add effective 03/15/2024<br>Retire effecitve 06/30/2024 |
| Q4294 | Amnio Quad-Core 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). | 7/1/2024 | _ | Add effective 07/01/2024 |
| Q4295 | Amnio Tri-Core Amniotic Per Square Centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024 | 6/30/2024 | Add effective 03/15/2024<br>Retire effecitve 06/30/2024 |
| Q4295 | Amnio Tri-Core Amniotic 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). | 7/1/2024 | _ | Add effective 07/01/2024 |
| Q4296 | Rebound Matrix Per Square Centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024 | 6/30/2024 | Add effective 03/15/2024<br>Retire effecitve 06/30/2024 |
| Q4296 | Rebound Matrix Per Square Centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024 | _ | Add effective 07/01/2024 |

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| Q4297 | Emerge Matrix Per Square Centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024 | 6/30/2024 | Add effective 03/15/2024<br>Retire effecitve 06/30/2024 |
| Q4297 | Emerge Matrix Per Square Centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024 | _ | Add effective 07/01/2024 |
| Q4298 | Amnicore Pro Per Square Centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024 | 6/30/2024 | Add effective 03/15/2024<br>Retire effecitve 06/30/2024 |
| Q4298 | Amnicore Pro 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). | 7/1/2024 | _ | Add effective 07/01/2024 |
| Q4299 | Amnicore Pro+ Per Square Centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024 | 6/30/2024 | Add effective 03/15/2024<br>Retire effecitve 06/30/2024 |
| Q4299 | Amnicore Pro+ 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). | 7/1/2024 | _ | Add effective 07/01/2024 |
| Q4300 | Acesso Tl Per Square Centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024 | 6/30/2024 | Add effective 03/15/2024<br>Retire effecitve 06/30/2024 |
| Q4300 | Acesso Tl 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). | 7/1/2024 | _ | Add effective 07/01/2024 |
| Q4301 | Activate Matrix Per Square Centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024 | 6/30/2024 | Add effective 03/15/2024<br>Retire effecitve 06/30/2024 |
| Q4301 | Activate Matrix Per Square Centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024 | _ | Add effective 07/01/2024 |
| Q4302 | Complete Aca Per Square Centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024 | 6/30/2024 | Add effective 03/15/2024<br>Retire effecitve 06/30/2024 |
| Q4302 | Complete Aca 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). | 7/1/2024 | _ | Add effective 07/01/2024 |
| Q4303 | Complete Aa Per Square Centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024 | 6/30/2024 | Add effective 03/15/2024<br>Retire effecitve 06/30/2024 |
| Q4303 | Complete Aa 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). | 7/1/2024 | _ | Add effective 07/01/2024 |
| Q4304 | Grafix Plus Per Square Centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024 | _ | Add effective 03/15/2024 |

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| Q4305 | American Amnion Ac Tri-Layer 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). | 4/1/2024 | – | Add effective 04/01/2024 |
| Q4306 | American Amnion Ac 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). | 4/1/2024 | – | Add effective 04/01/2024 |
| Q4307 | American Amnion 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). | 4/1/2024 | – | Add effective 04/01/2024 |
| Q4308 | Sanopellis 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). | 4/1/2024 | – | Add effective 04/01/2024 |
| Q4309 | Via Matrix Per Square Centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2024 | – | Add effective 04/01/2024 |
| Q4310 | Procenta Per 100 Mg | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2024 | – | Add effective 04/01/2024 |
| Q5009 | Hospice Or Home Health Care Provided In Place Not Otherwise Specified (Nos) | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | – | – | – |
| Q5103 | Injection Infliximab-Dyyb Biosimilar (Inflectra) 10 Mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | – | – | – |
| Q5104 | Injection Infliximab-Abda Biosimilar (Renflexis) 10 Mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | – | – | – |
| Q5106 | Injection Epoetin Alfa-Epbx Biosimilar (Retacrit) (For Non-Esrd Use) 1000 Units | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | – | – | – |
| Q5109 | Injection Infliximab-Qbtx Biosimilar (Ixifi) 10 Mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | – | – | – |

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| Q5124 | Injection Ranibizumab-Nuna Biosimilar (Byooviz) 0.1 Mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| Q5128 | Injection Ranibizumab-Eqrn (Cimerli) Biosimilar 0.1 Mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| Q5133 | Injection Tocilizumab-Bavi (Tofidence) Biosimilar 1 Mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/1/2024 | _ | |
| Q5134 | Injection Natalizumab-Sztn (Tyruko) Biosimilar 1 Mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2024 | _ | Add effective 07/01/2024 |
| S0013 | Esketamine Nasal Spray 1 Mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| S0117 | Tretinoin Topical 5 Grams | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| S0142 | Colistimethate Sodium Inhalation Solution Administered Through Dme Concentrated Form Per Mg | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| 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. | _ | _ | _ |
| S0197 | Prenatal Vitamins 30-Day Supply | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| S0310 | Hospitalist Services (List Separately In Addition To Code For Appropriate Evaluation And Management Service) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| S0320 | Telephone Calls By A Registered Nurse To A Disease Management Program Member For Monitoring Purposes; Per Month | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| S0590 | Integral Lens Service Miscellaneous Services Reported Separately | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| S0596 | Phakic Intraocular Lens For Correction Of Refractive Error | 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 |
| S0622 | Physical Exam For College New Or Established Patient (List Separately In Addition To Appropriate Evaluation And Management Code) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| S0800 | Laser In Situ Keratomileusis (Lasik) | MP Criteria: Procedure/service reviewed against Medical 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 Basic Item) | Unlisted: Procedure/service not specifically defined or 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 classified, maybe subject to contract/clinical review. | _ | _ | _ |

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| S1091 | Stent Non-Coronary Temporary With Delivery System (Propel) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| S2053 | Transplantation Of Small Intestine And Liver Allografts | 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 |
| S2054 | Transplantation Of Multivisceral Organs | 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 |
| S2060 | Lobar Lung Transplantation | 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 |
| S2065 | Simultaneous Pancreas Kidney Transplantation | 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 |
| S2083 | Adjustment Of Gastric Band Diameter Via Subcutaneous Port By Injection Or Aspiration Of Saline | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| S2112 | Arthroscopy Knee Surgical For Harvesting Of Cartilage (Chondrocyte Cells) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| S2117 | Arthroereisis Subtalar | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| S2118 | Metal-On-Metal Total Hip Resurfacing Including Acetabular And Femoral Components | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| S2120 | Low Density Lipoprotein (Ldl) Apheresis Using Heparin-Induced Extracorporeal Ldl Precipitation | 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. | _ | _ | _ |
| S2140 | Cord Blood Harvesting For Transplantation Allogeneic | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| S2142 | Cord Blood-Derived Stem-Cell Transplantation Allogeneic | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| S2150 | 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 Therapy; Drugs Supplies Hospitalization With Outpatient Follow-Up; Medical/Surgical Diagnostic Emergency And Rehabilitative Services; And The Number Of Days Of Pre-And Post-Transplant Care In The Global Definition | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |

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

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| S3650 | Saliva Test Hormone Level; During Menopause | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| S3652 | Saliva Test Hormone Level; To Assess Preterm Labor Risk | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| S3800 | Genetic Testing For Amyotrophic Lateral Sclerosis (Als) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| S3840 | Dna Analysis For Germline Mutations Of The Ret Proto-Oncogene For Susceptibility To Multiple Endocrine Neoplasia Type 2 | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| S3841 | Genetic Testing For Retinoblastoma | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| S3842 | Genetic Testing For Von Hippel-Lindau Disease | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| S3844 | Dna Analysis Of The Connexin 26 Gene (Gjb2) For Susceptibility To Congenital Profound Deafness | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| S3845 | Genetic Testing For Alpha-Thalassemia | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| S3846 | Genetic Testing For Hemoglobin E Beta-Thalassemia | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| S3849 | Genetic Testing For Niemann-Pick Disease | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| S3850 | Genetic Testing For Sickle Cell Anemia | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| S3852 | Dna Analysis For Apoe Epsilon 4 Allele For Susceptibility To Alzheimer'S Disease | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| S3853 | Genetic Testing For Myotonic Muscular Dystrophy | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| S3854 | Gene Expression Profiling Panel For Use In The Management Of Breast Cancer Treatment | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| S3861 | Genetic Testing Sodium Channel Voltage-Gated Type V Alpha Subunit (Scn5A) And Variants For Suspected Brugada Syndrome | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| S3865 | Comprehensive Gene Sequence Analysis For Hypertrophic Cardiomyopathy | 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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| S3866 | Genetic Analysis For A Specific Gene Mutation For Hypertrophic Cardiomyopathy (Hcm) In An Individual With A Known Hcm Mutation In The Family | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| S3870 | Comparative Genomic Hybridization (Cgh) Microarray Testing For Developmental Delay Autism Spectrum Disorder And/Or Intellectual Disability | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| S3900 | Surface Electromyography (Emg) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| S4015 | Complete In Vitro Fertilization Cycle Not Otherwise Specified Case Rate | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| S4023 | Donor Egg Cycle Incomplete Case Rate | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| S4025 | Donor Services For In Vitro Fertilization (Sperm Or Embryo) Case Rate | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| S4026 | Procurement Of Donor Sperm From Sperm Bank | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| S4027 | Storage Of Previously Frozen Embryos | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| S4030 | Sperm Procurement And Cryopreservation Services; Initial Visit | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| S4031 | Sperm Procurement And Cryopreservation Services; Subsequent Visit | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| S4040 | Monitoring And Storage Of Cryopreserved Embryos Per 30 Days | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to 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 (E. G. Pump Maintenance) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| S5036 | Home Infusion Therapy Repair Of Infusion Device (E. G. Pump Repair) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| S5100 | Day Care Services Adult; Per 15 Minutes | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| S5101 | Day Care Services Adult; Per Half Day | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |

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| S5102 | Day Care Services Adult; Per Diem | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| S5105 | Day Care Services Center-Based; Services Not Included In Program Fee Per Diem | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| S5108 | Home Care Training To Home Care Client Per 15 Minutes | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| S5109 | Home Care Training To Home Care Client Per Session | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| S5110 | Home Care Training Family; Per 15 Minutes | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| S5111 | Home Care Training Family; Per Session | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| S5115 | Home Care Training Non-Family; Per 15 Minutes | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| S5116 | Home Care Training Non-Family; Per Session | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| S5120 | Chore Services; Per 15 Minutes | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| S5121 | Chore Services; Per Diem | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| S5125 | Attendant Care 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. Not subject to pre-service review. | _ | _ | _ |
| S5130 | Homemaker Service Nos; Per 15 Minutes | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted or Undefined: Procedures/services not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| S5131 | Homemaker Service Nos; Per Diem | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted or Undefined: Procedures/services not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| S5135 | Companion Care Adult (E. G. Iadl/Adl); Per 15 Minutes | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| S5136 | Companion Care Adult (E. G. Iadl/Adl); Per Diem | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| S5140 | Foster Care Adult; Per Diem | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| S5141 | Foster Care Adult; Per Month | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| S5145 | Foster Care Therapeutic Child; Per Diem | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| S5146 | Foster Care Therapeutic Child; Per Month | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |

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| S5150 | Unskilled Respite Care Not Hospice; Per 15 Minutes | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| S5151 | Unskilled Respite Care Not Hospice; Per Diem | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| S5160 | Emergency Response System; Installation And Testing | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| S5161 | Emergency Response System; Service Fee Per Month (Excludes Installation And Testing) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| S5162 | Emergency Response System; Purchase Only | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| S5165 | Home Modifications; Per Service | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| S5170 | Home Delivered Meals Including Preparation; Per Meal | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| S5175 | Laundry Service External Professional; Per Order | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| S5181 | Home Health Respiratory Therapy Nos Per Diem | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| S5185 | Medication Reminder Service Non-Face-To-Face; Per Month | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| S5199 | Personal Care Item Nos Each | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted or Undefined: Procedures/services not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| S5497 | Home Infusion Therapy Catheter Care / Maintenance Not Otherwise Classified; Includes Administrative Services Professional Pharmacy Services Care Coordination And All Necessary Supplies And Equipment (Drugs And Nursing Visits Coded Separately) Per Diem | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| S8030 | Scleral Application Of Tantalum Ring(S) For Localization Of Lesions For Proton Beam Therapy | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by Carelon. | _ | _ | _ |
| S8035 | Magnetic Source Imaging | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| S8037 | Magnetic Resonance Cholangiopancreatography (Mrcp) | MP Criteria: Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review by BCBS. | _ | _ | _ |
| S8040 | Topographic Brain Mapping | 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 |
| S8130 | Interferential Current Stimulator 2 Channel | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |

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| S8131 | Interferential Current Stimulator 4 Channel | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| S8189 | Tracheostomy Supply Not Otherwise Classified | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| S8270 | Enuresis Alarm Using Auditory Buzzer And/Or Vibration Device | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| S8301 | Infection Control Supplies Not Otherwise Specified | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| S8460 | Camisole Post-Mastectomy | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| S8930 | Electrical Stimulation Of Auricular Acupuncture Points; Each 15 Minutes Of Personal One-On-One Contact With The Patient | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| S8940 | Equestrian/Hippotherapy Per Session | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| S8948 | Application Of A Modality (Requiring Constant Provider Attendance) To One Or More Areas; Low-Level Laser; Each 15 Minutes | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| S8990 | Physical Or Manipulative Therapy Performed For Maintenance Rather Than Restoration | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| S9001 | Home Uterine Monitor With Or Without Associated Nursing Services | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| S9002 | Intra-Vaginal Motion Sensor System Provides Biofeedback For Pelvic Floor Muscle Rehabilitation Device | 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 |
| S9056 | Coma Stimulation Per Diem | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| S9090 | Vertebral Axial Decompression Per Session | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | _ | _ | _ |
| S9117 | Back School Per Visit | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| S9125 | Respite Care In The Home Per Diem | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| S9335 | Home Therapy Hemodialysis; Administrative Services Professional Pharmacy Services Care Coordination And All Necessary Supplies And Equipment (Drugs And Nursing Services Coded Separately) Per Diem | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |

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

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| S9558 | 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 | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| S9562 | 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 | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| S9810 | 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) | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| S9900 | Services By A Journal-Listed Christian Science Practitioner For The Purpose Of Healing Per Diem | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| S9970 | Health Club Membership Annual | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| S9975 | Transplant Related Lodging Meals And Transportation Per Diem | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| S9976 | Lodging Per Diem Not Otherwise Classified | 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. | _ | _ | _ |
| S9977 | Meals Per Diem 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. | _ | _ | _ |
| 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 Service Not Medically Necessary) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| S9988 | 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. | _ | _ | _ |
| S9990 | 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. | _ | _ | _ |
| S9991 | 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. | _ | _ | _ |
| S9992 | Transportation Costs To And From Trial Location And Local Transportation Costs (E. G. Fares For Taxicab Or Bus) For Clinical Trial Participant And One Caregiver/Companion | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |

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| S9994 | Lodging Costs (E. G. Hotel Charges) For Clinical Trial Participant And One Caregiver/Companion | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| S9996 | Meals For Clinical Trial Participant And One Caregiver/Companion | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| S9999 | Sales Tax | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| T1014 | Telehealth Transmission Per Minute Professional Services Bill Separately | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | _ | _ | _ |
| T1505 | Electronic Medication Compliance Management Device Includes All Components And Accessories Not Otherwise Classified | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| T1999 | Miscellaneous Therapeutic Items And Supplies Retail Purchases Not Otherwise Classified; Identify Product In Remarks | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| T2012 | Habilitation Educational; Waiver Per Diem | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| T2013 | Habilitation Educational Waiver; Per Hour | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| T2014 | Habilitation Prevocational Waiver; Per Diem | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| T2015 | Habilitation Prevocational Waiver; Per Hour | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| T2016 | Habilitation Residential Waiver; Per Diem | Unlisted: Procedure/service not specifically defined or 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 Minutes | Unlisted: Procedure/service not specifically defined or 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 classified, maybe subject to contract/clinical review. | _ | _ | _ |
| T2027 | Specialized Childcare Waiver; Per 15 Minutes | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| T2028 | Specialized Supply Not Otherwise Specified Waiver | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| T2029 | Specialized Medical Equipment Not Otherwise Specified Waiver | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |

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

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| V2799 | Vision Item Or Service Miscellaneous | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.<br>Unlisted or Undefined: Procedures/services not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| V5090 | Dispensing Fee Unspecified Hearing Aid | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| V5095 | Semi-Implantable Middle Ear Hearing Prosthesis | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| V5267 | Hearing Aid Or Assistive Listening Device/Supplies/Accessories Not Otherwise Specified | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| V5274 | Assistive Listening Device Not Otherwise Specified | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| V5287 | Assistive Listening Device Personal Fm/Dm Receiver Not Otherwise Specified | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| V5298 | Hearing Aid Not Otherwise Classified | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| V5299 | Hearing Service Miscellaneous | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | _ | _ | _ |
| V5362 | Speech Screening | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| V5363 | Language Screening | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | _ | _ | _ |
| 20982 | 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; Radiofrequency | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2024 | _ | Add effective 06/01/2024 |
| 50541 | Laparoscopy Surgical; Ablation Of Renal Cysts | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2024 | _ | Add effective 06/01/2024 |
| 50542 | Laparoscopy Surgical; Ablation Of Renal Mass Lesion(S) Including Intraoperative Ultrasound Guidance And Monitoring When Performed | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2024 | _ | Add effective 06/01/2024 |
| 0858T | Externally Applied Transcranial Magnetic Stimulation With Concomitant Measurement Of Evoked Cortical Potentials With Automated Report | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2024 | _ | Add effective 06/01/2024 |
| 0452U | Oncology (bladder), methylated PENK DNA detection by linear target enrichment-quantitative methylation-specific real-time PCR (LTE-qMSP), urine, reported as likelihood of bladder 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 |

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| 0453U | Oncology (colorectal cancer), cellfree DNA (cfDNA), methylation-based quantitative PCR assay (SEPTIN9, IKZF1, BCAT1, Septin9-2, VAV3, BCAN), plasma, reported as presence or absence of circulating tumor DNA (ctDNA) | 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 |
| 0454U | Rare diseases (constitutional/heritable disorders), identification of copy number variations, inversions, insertions, translocations, and other structural variants by optical genome mapping | 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 |
| 0456U | Autoimmune (rheumatoid arthritis), next-generation sequencing (NGS), gene expression testing of 19 genes, | 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. | | | |
| | whole blood, with analysis of anti-cyclic citrullinated peptides (CCP) levels, combined with sex, patient global assessment, and body mass index (BMI), algorithm reported as a score that predicts nonresponse to tumor necrosis factor inhibitor (TNFi) therapy | 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 |
| 0460U | Oncology, whole blood or buccal, DNA single-nucleotide polymorphism (SNP) genotyping by real-time PCR of 24 genes, with variant analysis and reported phenotypes | 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 |
| 0461U | Oncology, pharmacogenomic analysis of single-nucleotide polymorphism (SNP) genotyping by real-time PCR of 24 genes, whole blood or buccal swab, with variant analysis, including impacted gene-drug interactions and reported phenotypes | 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 |
| 0465U | Oncology (urothelial carcinoma), DNA, quantitative methylation-specific PCR of 2 genes (ONECUT2, VIM), algorithmic analysis reported as positive or negative | 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 |
| 0466U | Cardiology (coronary artery disease [CAD]), DNA, genome-wide association studies (564856 single-nucleotide polymorphisms [SNPs], targeted variant genotyping), patient lifestyle and clinical data, buccal swab, algorithm reported as polygenic risk to acquired heart disease | 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 |
| 0467U | Oncology (bladder), DNA, next-generation sequencing (NGS) of 60 genes and whole genome aneuploidy, urine, algorithms reported as minimal residual disease (MRD) status positive or negative and quantitative disease 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 |

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| 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 |

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| 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. | | – | |
| J9361 | Ryzneuta (efbemalenograstim alfa-vuxw) | 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. | | – | |
| J9035 | Injection Bevacizumab 10 Mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | – | – | |
| C9257 | Injection Bevacizumab 0.25 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 |
| J0565 | Injection Bezlotoxumab 10 Mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | – | 10/1/2024 | Retire effective 10/1/2024 |
| J1675 | Injection Histrelin Acetate 10 Micrograms | 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 |
| J1950 | Injection Leuprolide Acetate (For Depot Suspension) Per 3. 75 Mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | – | 10/1/2024 | Retire effective 10/1/2024 |
| J2278 | Injection Ziconotide 1 Microgram | 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 |
| J2502 | Injection Pasireotide Long Acting 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 |
| 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 |

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| J3285 | Injection Treprostinil 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 |
| J3315 | Injection Triptorelin Pamoate 3. 75 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 |
| J7178 | Injection Human Fibrinogen Concentrate Not Otherwise Specified 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 |
| J7340 | Carbidopa 5 Mg/Levodopa 20 Mg Enteral Suspension 100 Ml | 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 |
| J9155 | Injection Degarelix 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 |
| J9202 | Goserelin Acetate Implant Per 3. 6 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 |
| J9217 | Leuprolide Acetate (For Depot Suspension) 7. 5 Mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | – | 10/1/2024 | Retire effective 10/1/2024 |
| J9218 | Leuprolide Acetate Per 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 |
| J9219 | Leuprolide Acetate Implant 65 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 |
| J9225 | Histrelin Implant (Vantas) 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 required per contract agreement. | – | 10/1/2024 | Retire 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 required per contract agreement. | – | 10/1/2024 | Retire effective 10/1/2024 |

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| 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 |



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.

Availity is a trademark of Availity, LLC, a separate company that operates a health information network to provide electronic information exchange services to medical professionals. Availity provides administrative services to BCBSNM.

Carelon Medical Benefits Management is an independent company that has contracted with BCBSNM to provide utilization management services for members with coverage through BCBSNM.

BCBSNM makes no endorsement, representations or warranties regarding any products or services provided by third party vendors such as Availity or Carelon Medical Benefits Management. If you have any questions about the products or services offered by such vendors, you should contact the vendor(s) directly.

Blue Cross and Blue Shield of New Mexico, A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association