2023

Prior Authorization List

The Provider Authorization List was last updated April 1, 2023.

- The results of this tool are not a guarantee of coverage or authorization.
- Recommendations contained in InterQual guidelines are not a guarantee of coverage.
- The contents of this list are subject to change in accordance with plan policies and procedures and the Provider Manual.
- Providers should consult applicable medical policies for information regarding covered benefits.

Prior authorizations are required for:

- All non-par providers.
- Out-of-state providers.
- All inpatient admissions, including organ transplants.
- Durable medical equipment over \$500.
- Elective surgeries.
- Any service that requires an authorization from a primary payer,
 except nonexhausted Original Medicare Services.
- Any exhausted or noncovered Original Medicare service.

For more information, call Provider Services by calling 1–844–325–6251 from 8 a.m. – 5 p.m., Monday through Friday, or contacting your Provider Account Liaison.





		HEALTH OPTIONS
Abortion	Codes	Prior Authorization Requirement
Induced abortion, by dilation and curettage	59840	Prior authorization is required, elective abortions are not covered.
Induced abortion, by dilation and evacuation Induced abortion, by 1 or more intra-amniotic	59841 59850	Prior authorization is required, elective abortions are not covered. Prior authorization is required, elective abortions are not covered.
injections (amniocentesis-injections),	59850	Prior authorization is required, elective abortions are not covered.
including hospital admission and visits,		
delivery of fetus and secundines; Induced abortion, by 1 or more intra-amniotic	59851	Prior authorization is required, elective abortions are not covered.
injections (amniocentesis-injections),	55651	i noi authorizationis required, elective abortions are not covered.
including hospital admission and visits,		
delivery of fetus and secundines; with dilation and curettage and/or evacuation		
Induced abortion, by 1 or more intra-amniotic	59852	Prior authorization is required, elective abortions are not covered.
injections (amniocentesis-injections), including hospital admission and visits.		
delivery of fetus and secundines; with		
hysterotomy (failed intra-amniotic injection)		
Induced abortion, by 1 or more vaginal	59855	Prior authorization is required, elective abortions are not covered.
suppositories (eg, prostaglandin) with or	33633	Frior authorization is required, elective abortions are not covered.
without cervical dilation (eg, laminaria),		
including hospital admission and visits, delivery of fetus and secundines;		
Induced abortion, by 1 or more vaginal	59856	Prior authorization is required, elective abortions are not covered.
suppositories (eg, prostaglandin) with or		
without cervical dilation (eg, laminaria),		
including hospital admission and visits, delivery of fetus and secundines; with dilation		
and curettage and/or evacuation		
Induced abortion, by 1 or more vaginal	59857	Prior authorization is required, elective abortions are not covered.
suppositories (eg, prostaglandin) with or without cervical dilation (eg, laminaria),		
including hospital admission and visits,		
delivery of fetus and secundines; with		
hysterotomy (failed medical evacuation) Multifetal pregnancy reduction(s) (MPR)	59866	Prior authorization is required, elective abortions are not covered.
Medically induced abortion by oral ingestion	50199	Prior authorization is required, elective abortions are not covered.
of medication including all associated		
services and supplies (e.g., patient		
counseling, office visits, confirmation of pregnancy by HCG, ultrasound to confirm		
duration of pregnancy, ultrasound to confirm		
completion of abortion) except drugs		
Induced abortion, 17 to 24 weeks	S2260	Prior authorization is required, elective abortions are not covered.
Induced abortion, 25 to 28 weeks	\$2265	Prior authorization is required, elective abortions are not covered.
Induced abortion, 29 to 31 weeks	S2266	Prior authorization is required, elective abortions are not covered.
Induced abortion, 32 weeks or greater Sterilization	S2267 Codes	Prior authorization is required, elective abortions are not covered. Prior Authorization Requirement
Vasotomy, cannulization with or without	55200	For members 21 and older, a signed consent or awareness form is required with prior authorization.
incision of vas, unilateral or bilateral	35200	For members 21 and order, a signed consent or awareness form is required with prior authorization.
(separate procedure)		
Vasectomy, unilateral or bilateral (separate	55250	For members 21 and older, a signed consent or awareness form is required with prior authorization.
procedure), including postoperative semen examination(s)		
Vasotomy for vasograms, seminal	55300	For members 21 and older, a signed consent or awareness form is required with prior authorization.
vesiculograms, or epididymograms, unilateral		
or bilateral Ligation or transection of fallopian tube(s),	58600	For members 21 and older, a signed consent or awareness form is required with prior authorization.
abdominal or vaginal approach, unilateral or	58888	To members 21 and older, a signed consent of awareness form is required with prior authorization.
bilateral		
Ligation or transection of fallopian tube(s), abdominal or vaginal approach, postpartum,	58605	For members 21 and older, a signed consent or awareness form is required with prior authorization.
unilateral or bilateral, during same		
hospitalization (separate procedure)		
Ligation or transection of fallopian tube(s) when done at the time of cesarean delivery or	58611	For members 21 and older, a signed consent or awareness form is required with prior authorization.
intra-abdominal surgery (not a separate		
procedure) (List separately in addition to		
code for primary procedure) Laparoscopy, surgical; with occlusion of	58671	For members 21 and older, a signed consent or awareness form is required with prior authorization.
oviducts by device (eg, band, clip, or Falope	56071	To members 21 and order, a signed consent of awareness form is required with prior authorization.
ring)		
Hysterectomy	Codes	Prior Authorization Requirement
Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s),	58150	Prior authorization is required, medical necessity criteria must be met.
with or without removal of ovary(s);		
Total abdominal hysterectomy (corpus and	58152	Prior authorization is required, medical necessity criteria must be met.
cervix), with or without removal of tube(s), with or without removal of ovary(s); with colpo		
urethrocystopexy (eg, Marshall-Marchetti-		
Krantz, Burch)	50400	
Supracervical abdominal hysterectomy (subtotal hysterectomy), with or without	58180	Prior authorization is required, medical necessity criteria must be met.
removal of tube(s), with or without removal of		
ovary(s)	50000	
Total abdominal hysterectomy, including partial vaginectomy, with para-aortic and	58200	Prior authorization is required, medical necessity criteria must be met.
pelvic lymph node sampling, with or without		
removal of tube(s), with or without removal of		
ovary(s) Radical abdominal hysterectomy, with	58210	Prior authorization is required, medical necessity criteria must be met.
bilateral total pelvic lymphadenectomy and	30210	inor authorization is required, medical necessity criteria must be met.
para-aortic lymph node sampling (biopsy),		
with or without removal of tube(s), with or without removal of ovary(s)		
Pelvic exenteration for gynecologic	58240	Prior authorization is required, medical necessity criteria must be met.
malignancy, with total abdominal		
hysterectomy or cervicectomy, with or without removal of tube(s), with or without		
without removal of tube(s), with or without removal of ovary(s), with removal of bladder		
and ureteral transplantations, and/or		
abdominoperineal resection of rectum and		
colon and colostomy, or any combination thereof		
Vaginal hysterectomy, for uterus 250 g or	58260	Prior authorization is required, medical necessity criteria must be met.
less;		
Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s)	58262	Prior authorization is required, medical necessity criteria must be met.
soos, with removal of tube(s), and/of ovary(s)		
Vaginal hysterectomy, for uterus 250 g or	58263	Prior authorization is required, medical necessity criteria must be met.
less; with removal of tube(s), and/or ovary(s), with repair of enterocele		
with repair of enterocele Vaginal hysterectomy, for uterus 250 g or	58267	Prior authorization is required, medical necessity criteria must be met.
less; with colpo-urethrocystopexy (Marshall-		
Marchetti-Krantz type, Pereyra type) with or without endoscopic control		
manous enacecopic control	<u>i</u>	

Vaginal hysterectomy, for uterus 250 g or less; with repair of enterocele	58270	Prior authorization is required, medical necessity criteria must be met.
Vaginal hysterectomy, with total or partial vaginectomy	58275	Prior authorization is required, medical necessity criteria must be met.
Vaginal hysterectomy, with total or partial	58280	Prior authorization is required, medical necessity criteria must be met.
vaginectomy; with repair of enterocele Vaginal hysterectomy, radical (Schauta type	58285	Prior authorization is required, medical necessity criteria must be met.
operation) Vaginal hysterectomy, for uterus greater than	58290	Prior authorization is required, medical necessity criteria must be met.
250 g; Vaginal hysterectomy, for uterus greater than		Prior authorization is required, medical necessity criteria must be met.
250 g; with removal of tube(s) and/or ovary(s) Vaginal hysterectomy, for uterus greater than	59707	Prior authorization is required, medical necessity criteria must be met.
250 g; with removal of tube(s) and/or ovary(s), with repair of enterocele	30232	Thor authorization is required, medical necessity criteria must be met.
Vaginal hysterectomy, for uterus greater than 250 g; with repair of enterocele	58294	Prior authorization is required, medical necessity criteria must be met.
Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)	58552	Prior authorization is required, medical necessity criteria must be met.
Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)	58554	Prior authorization is required, medical necessity criteria must be met.
Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g;	58553	Prior authorization is required, medical necessity criteria must be met.
Transplants/Implants	Codes	Prior Authorization Requirement
Lung transplant, single; without cardiopulmonary bypass	32851	Prior authorization is required.
Lung transplant, single; with cardiopulmonary bypass	32852	Prior authorization is required.
Lung transplant, double (bilateral sequential or en bloc); without cardiopulmonary bypass	32853	Prior authorization is required.
Lung transplant, double (bilateral sequential or en bloc); with cardiopulmonary bypass	32854	Prior authorization is required.
Heart-lung transplant with recipient cardiectomy-pneumonectomy	33935	Prior authorization is required.
Backbench standard preparation of cadaver	33945	Prior authorization is required.
donor heart allograft prior to transplantation, including dissection of allograft from		
surrounding soft tissues to prepare aorta, superior vena cava, inferior vena cava,		
pulmonary artery, and left atrium for implantation		
Bone marrow harvesting for transplantation;	38230	Prior authorization is required.
allogeneic Bone marrow harvesting for transplantation;	38232	Prior authorization is required.
autologous Allogeneic lymphocyte infusions	38242	Prior authorization is required.
Liver allotransplantation, orthotopic, partial or	47135	Prior authorization is required.
whole, from cadaver or living donor, any age Pancreatectomy, total or subtotal, with	48160	Prior authorization is required.
autologous transplantation of pancreas or pancreatic islet cells		
Donor pancreatectomy (including cold preservation), with or without duodenal segment for transplantation	48550	Prior authorization is required.
Transplantation of pancreatic allograft Removal of transplanted pancreatic allograft	48554 48556	Prior authorization is required. Prior authorization is required.
Renal allotransplantation, implantation of	50360	Prior authorization is required.
graft; without recipient nephrectomy Renal allotransplantation, implantation of	50365	Prior authorization is required.
graft; with recipient nephrectomy Removal of transplanted renal allograft	50370	Prior authorization is required.
Renal autotransplantation, reimplantation of kidney	50380	Prior authorization is required.
Keratoplasty (corneal transplant); anterior	65710	Prior authorization is required.
lamellar Keratoplasty (corneal transplant); penetrating (except in aphakia or pseudophakia)	65730	Prior authorization is required.
Keratoplasty (corneal transplant); penetrating (in aphakia)		Prior authorization is required.
Keratoplasty (corneal transplant); penetrating (in pseudophakia)	65755	Prior authorization is required.
Keratoplasty (corneal transplant); endothelial	65756	Prior authorization is required.
Ocular surface reconstruction; amniotic membrane transplantation, multiple layers	65780	Prior authorization is required.
Percutaneous islet cell transplant, includes	G0341	Prior authorization is required.
portal vein catheterization and infusion Transplantation of small intestine and liver	52053	Prior authorization is required.
allografts Transplantation of multivisceral organs	S2054	Prior authorization is required.
Lobar lung transplantation	S2060	Prior authorization is required.
Donor lobectomy (lung) for transplantation, living donor	52061	Prior authorization is required.
Simultaneous pancreas kidney transplantation	52065	Prior authorization is required.
Islet cell tissue transplant from pancreas; allogeneic	52102	Prior authorization is required.
Bone marrow or blood-derived stem cells	52150	Prior authorization is required.
(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		
diagnostic, emergency, and rehabilitative services; and the number of days of pre- and posttransplant care in the global definition Solid organ(s), complete or segmental, single	52152	Prior authorization is required.
diagnostic, emergency, and rehabilitative services; and the number of days of pre- and posttransplant care in the global definition	52152	Prior authorization is required.
diagnostic, emergency, and rehabilitative services; and the number of days of pre- and posttransplant care in the global definition Solid organ(s), complete or segmental, single organ or combination of organs; deceased or living donor(s), procurement, transplantation, and related complications; including: drugs:	52152	Prior authorization is required.
diagnostic, emergency, and rehabilitative services; and the number of days of pre- and posttransplant care in the global definition Solid organ(s), complete or segmental, single organ or combination of organs; deceased or living donor(s), procurement, transplantation, and related complications; including; drugs; supplies; hospitalization with outpatient follow up; medical/surgical, diagnostic, emergency.	52152	Prior authorization is required.
diagnostic, emergency, and rehabilitative services; and the number of days of pre- and posttransplant care in the global definition. Solid organ(s), complete or segmental, single organ or combination of organs; deceased or living donor(s), procurement, transplantation, and related complications; including; drugs; supplies; hospitalization with outpatient follow up; medical/surgical, diagnostic, emergency, and rehabilitative services, and the number of days of pre- and posttransplant care in the	52152	Prior authorization is required.
diagnostic, emergency, and rehabilitative services; and the number of days of pre- and posttransplant care in the global definition Solid organ(s), complete or segmental, single organ or combination of organs; deceased or living donor(s), procurement, transplantation, and related complications; including: drugs; supplies; hospitalization with outpatient follow up; medical/surgical, diagnostic, emergency, and rehabilitative services, and the number of the number of the number of the number of the number of the number of the number of the number of	52152	Prior authorization is required.
diagnostic, emergency, and rehabilitative services; and the number of days of pre- and posttransplant care in the global definition. Solid organ(s), complete or segmental, single organ or combination of organs; deceased or living donor(s), procurement, transplantation, and related complications; including: drugs; supplies; hospitalization with outpatient follow up; medical/surgical, diagnostic, emergency, and rehabilitative services, and the number of days of pre- and posttransplant care in the global definition. Bony Impacted Wisdom Teeth	Codes	Prior Authorization Requirement
diagnostic, emergency, and rehabilitative services; and the number of days of pre-and posttransplant care in the global definition and posttransplant care in the global definition or combination of organs; deceased or living donor(s), procurement, transplantation, and related complications; including: drugs; supplies; hospitalization with outpatient follow up; medical/surgical, diagnostic, emergency, and rehabilitative services, and the number of days of pre- and posttransplant care in the global definition Bony Impacted Wisdom Teeth IMPACT TOOTH REMOV PART BONY	Codes D7230	Prior Authorization Requirement Prior authorization is required.
diagnostic, emergency, and rehabilitative services; and the number of days of pre- and posttransplant care in the global definition of the global	Codes D7230 D7240 D7241	Prior Authorization Requirement Prior authorization is required. Prior authorization is required. Prior authorization is required.
diagnostic, emergency, and rehabilitative services; and the number of days of pre-and posttransplant care in the global definition and posttransplant care in the global definition or combination of organs; deceased or living donorly, procurement, transplantation, and related complications; including; drugs; supplies; hospitalization with outpatient follow up; medical/surgical, diagnostic, emergency, and rehabilitative services, and the number of days of pre- and posttransplant care in the global definition Bony Impacted Wisdom Teeth IMPACT TOOTH REMOV PART BONY IMPACT TOOTH REMOV COMP BONY IMPACT TOOTH REM BONY W/COMP HOME HEAITH	Codes D7230 D7240	Prior Authorization Requirement Prior authorization is required. Prior authorization is required.
diagnostic, emergency, and rehabilitative services; and the number of days of pre- and posttransplant care in the global definition. Solid organ(s), complete or segmental, single organ or combination of organs; deceased or living donor(s), procurement, transplantation, and related complications; including; drugs; supplies; hospitalization with organization and enablitative services, and the number of days of pre- and posttransplant care in the global definition. Bony Impacted Wisdom Teeth IMPACT TOOTH REMOV PART BONY IMPACT TOOTH REMOV COMP BONY IMPACTTOOTH REMOV COMP BONY	Codes D7230 D7240 D7241	Prior Authorization Requirement Prior authorization is required. Prior authorization is required. Prior authorization is required.

Hospice Service-Routine Home Care	0651	Dries authorization is sequired
Hospice Service-Routine Home Care Hospice Service-Continuous Home Care	0651 0652	Prior authorization is required. Prior authorization is required.
Hospice Service-Inpatient Respite Care	0655	Prior authorization is required.
Hospice Service-General Inpatient Care	0656	Prior authorization is required.
Nonrespite Hospice Service-Physician Services	0657	Prior authorization is required.
Chiropractic Care	Codes	Prior Authorization Requirement
Chiropractic manipulative treatment (CMT); spinal, 1-2 regions	98940	For members under the age of 13 an authorization is required for all chiropractic services. For members 13+ authorization is required after the first 20 manipulations. Please refer to Chiropractic Benefit and Services Policy, HHO-RP-1120.
Chiropractic manipulative treatment (CMT); spinal, 3-4 regions	98941	For members under the age of 13 an authorization is required for all chiropractic services. For members 13+ authorization is required after the first 20 manipulations. Please refer to Chiropractic Benefit and Services Policy, HHO-RP-1120.
Chiropractic manipulative treatment (CMT); spinal, 5 regions	98942	For members under the age of 13 an authorization is required for all chiropractic services. For members 13+ authorization is required after the first 20 manipulations. Please refer to Chiropractic Benefit and Services Policy, HiO-RP-1120.
Chiropractic manipulative treatment (CMT); extraspinal, 1 or more regions	98943	For members under the age of 13 an authorization is required for all chiropractic services. For members 13+ authorization is required after the first 20 manipulations. Please refer to Chiropractic Benefit and Services Policy, HiO-RP-1120.
Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.	99202	Evaluation and Management (E/M) services after the pre-manipulation assessment require prior authorization. Please refer to Chiropractic Benefit and Services Policy, HHO-RP-1120.
Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.	99203	Evaluation and Management (E/M) services after the pre-manipulation assessment require prior authorization. Please refer to Chiropractic Benefit and Services Policy, HHO-RP-1120.
Office or other outpalient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.	99204	Evaluation and Management (E/M) services after the pre-manipulation assessment require prior authorization. Please refer to Chiropractic Benefit and Services Policy, HHO-RP-1120.
Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical discision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter	99205	Evaluation and Management (E/M) services after the pre-manipulation assessment require prior authorization. Please refer to Chiropractic Benefit and Services Policy, HHO-RP-1120.
Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional	99211	Evaluation and Management (E/M) services after the pre-manipulation assessment require prior authorization. Please refer to Chiropractic Benefit and Services Policy, HHO-RP-1120.
Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.	99212	Evaluation and Management (E/M) services after the pre-manipulation assessment require prior authorization. Please refer to Chiropractic Benefit and Services Policy, HHO-RP-1120.
Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.	99213	Evaluation and Management (E/M) services after the pre-manipulation assessment require prior authorization. Please refer to Chiropractic Benefit and Services Policy, HHO-RP-1120.
Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.	99214	Evaluation and Management (E/M) services after the pre-manipulation assessment require prior authorization. Please refer to Chiropractic Benefit and Services Policy, HHO-RP-1120.
Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.	99215	Evaluation and Management (E/M) services after the pre-manipulation assessment require prior authorization. Please refer to Chiropractic Benefit and Services Policy, HHO-RP-1120.
Radiologic examination, spine, single view, specify level Radiologic examination, spine, cervical; 2 or	72020	Coverage is limited to one set of x-rays for a member in a rolling twelve month period. Additional x-rays must be prior authorized. Please refer to Chiropractic Benefit and Services Policy, HHO-RP-1120.
3 views Radiologic examination, spine, cervical; 4 or	72050	Coverage is limited to one set of x-rays for a member in a rolling twelve month period. Additional x-rays must be prior authorized. Please refer to Chiropractic Benefit and Services Policy, HHO-RP-1120. Coverage is limited to one set of x-rays for a member in a rolling twelve month period. Additional x-rays must
5 views Radiologic examination, spine, cervical; 6 or	72052	be prior authorized. Please refer to Chiropractic Benefit and Services Policy, HHO-RP-1120. Coverage is limited to one set of x-rays for a member in a rolling twelve month period. Additional x-rays must
Radiologic examination, spine, cervical; 6 or more views Radiologic examination, spine; thoracic, 2	72070	Coverage is limited to one set of x-rays for a member in a rolling twelve month period. Additional x-rays must be prior authorized. Please refer to Chiropractic Benefit and Services Policy, HHO-RP-1120. Coverage is limited to one set of x-rays for a member in a rolling twelve month period. Additional x-rays must
views Radiologic examination, spine; thoracic, 3	72072	be prior authorized. Please refer to Chiropractic Benefit and Services Policy, HHO-RP-1120. Coverage is limited to one set of x-rays for a member in a rolling twelve month period. Additional x-rays must
views Radiologic examination, spine, thoracic,	72074	be prior authorized. Please refer to Chiropractic Benefit and Services Policy, HHO-RP-1120. Coverage is limited to one set of x-rays for a member in a rolling twelve month period. Additional x-rays must
	72080	be prior authorized. Please refer to Chiropractic Benefit and Services Policy, HHO-RP-1120. Coverage is limited to one set of x-rays for a member in a rolling twelve month period. Additional x-rays must
junction, minimum of 2 views Radiologic Examination, spine, entire thoracic and lumbar, including skull, cervical and sacral spine if performed (e.g. scoliosis	72081	be prior authorized. Please refer to Chiropractic Benefit and Services Policy, HHO-RP-1120. Coverage is limited to one set of x-rays for a member in a rolling twelve month period. Additional x-rays must be prior authorized. Please refer to Chiropractic Benefit and Services Policy, HHO-RP-1120.
evaluation); 1 view Radiologic Examination, spine, entire thoracic and lumbar, including skull, cervical and sacral spine if performed (e.g. scoliosis	72082	Coverage is limited to one set of x-rays for a member in a rolling twelve month period. Additional x-rays must be prior authorized. Please refer to Chiropractic Benefit and Services Policy, HHO-RP-1120.
evaluation); 2 or 3 views Radiologic Examination, spine, entire thoracic and lumbar, including skull, cervical and sacral spine if performed (e.g. scoliosis evaluation); 4 or 5 views	72083	Coverage is limited to one set of x-rays for a member in a rolling twelve month period. Additional x-rays must be prior authorized. Please refer to Chiropractic Benefit and Services Policy, HHO-RP-1120.

Radiologic Examination, spine, entire thoracic and lumbar, including skull, cervical and sacral spine if performed (e.g. scoliosis	72004	Common in limited to a company of the company of th
sacral spine if performed (e.g. scoliosis	72084	Coverage is limited to one set of x-rays for a member in a rolling twelve month period. Additional x-rays must be prior authorized. Please refer to Chiropractic Benefit and Services Policy, HHO-RP-1120.
evaluation); minimum of 6 views		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
Radiologic examination, spine, lumbosacral; 2	72100	Coverage is limited to one set of x-rays for a member in a rolling twelve month period. Additional x-rays must
or 3 views		be prior authorized. Please refer to Chiropractic Benefit and Services Policy, HHO-RP-1120.
Radiologic examination, spine, lumbosacral; minimum of 4 views	72110	Coverage is limited to one set of x-rays for a member in a rolling twelve month period. Additional x-rays must
Radiologic examination, spine, lumbosacral;	72114	be prior authorized. Please refer to Chiropractic Benefit and Services Policy, HHO-RP-1120. Coverage is limited to one set of x-rays for a member in a rolling twelve month period. Additional x-rays must
complete, including bending views, minimum	, 2224	be prior authorized. Please refer to Chiropractic Benefit and Services Policy, HHO-RP-1120.
of 6 views Radiologic examination, spine, lumbosacral:	72120	Coverage is limited to one set of x-rays for a member in a rolling twelve month period. Additional x-rays must
bending views only, 2 or 3 views		be prior authorized. Please refer to Chiropractic Benefit and Services Policy, HHO-RP-1120.
Radiologic examination, pelvis; 1 or 2 views	72170	Coverage is limited to one set of x-rays for a member in a rolling twelve month period. Additional x-rays must
Radiologic examination, pelvis; complete,	72190	be prior authorized. Please refer to Chiropractic Benefit and Services Policy, HHO-RP-1120.
minimum of 3 views	72190	Coverage is limited to one set of x-rays for a member in a rolling twelve month period. Additional x-rays must be prior authorized. Please refer to Chiropractic Benefit and Services Policy, HHO-RP-1120.
Radiologic Examination, sacroiliac joints; less	72200	Coverage is limited to one set of x-rays for a member in a rolling twelve month period. Additional x-rays must
than 3 views		be prior authorized. Please refer to Chiropractic Benefit and Services Policy, HHO-RP-1120.
Radiologic examination, sacroiliac joints; 3 or more views	72202	Coverage is limited to one set of x-rays for a member in a rolling twelve month period. Additional x-rays must
Radiologic examination, sacrum and coccyx,	72220	be prior authorized. Please refer to Chiropractic Benefit and Services Policy, HHO-RP-1120. Coverage is limited to one set of x-rays for a member in a rolling twelve month period. Additional x-rays must
minimum of 2 views	/2220	be prior authorized. Please refer to Chiropractic Benefit and Services Policy, HHO-RP-1120.
Facility-Based Behavioral Health Services	Codes	Prior Authorization Requirement
Inpatient (IP) Acute Psychiatric Inpatient (IP) Acute Psychiatric (semi-private	0114 0124	Prior authorization is required. Please refer to Facility-Based Behavioral Health Services, HHO-RP-1005. Prior authorization is required. Please refer to Facility-Based Behavioral Health Services, HHO-RP-1005.
two bed)	0124	Filor authorization is required. Flease relet to Facility-based behavioral realth Services, Priorite-1003.
Behavioral Health Treatment/Services- Extension of 090X-Partial HospitalizationLess	0912	Prior authorization is required. Please refer to Facility-Based Behavioral Health Services, HHO-RP-1005.
Intensive		
Behavioral Health Treatment/Services- Extension of 090X-Partial	0913	Prior authorization is required. Please refer to Facility-Based Behavioral Health Services, HHO-RP-1005.
HospitalizationIntensive		
Skilled Nursing Facility	Codes	Prior Authorization Requirement
Subacute Care-General	0190	Prior authorization is required. Skilled nursing benefit is up to 30 calendar days.
Subacute Care-Level II	0191 0192	Prior authorization is required. Skilled nursing benefit is up to 30 calendar days. Prior authorization is required. Skilled nursing benefit is up to 30 calendar days.
Subacute Care-Level III	0193	Prior authorization is required. Skilled nursing benefit is up to 30 calendar days.
Subacute Care-Level IV	0194	Prior authorization is required. Skilled nursing benefit is up to 30 calendar days.
Proton Beam	Codes	Prior Authorization Requirement
Proton treatment delivery; simple, without compensation	77520	Prior authorization is required.
Proton treatment delivery; simple, with	77522	Prior authorization is required.
compensation Proton treatment delivery; intermediate	77523	Prior authorization is required.
Proton treatment delivery; intermediate	77525	Prior authorization is required.
Scleral application of tantalum ring(s) for	S8030	Prior authorization is required.
localization of lesions for proton beam therapy		·
IMRT (Intensity Modulated Radiation	Codes	Prior Authorization Requirement
Therapy)		·
Intensity modulated radiation treatment delivery (IMRT), includes guidance and	77385	Prior authorization is required.
tracking, when performed; simple		
Intensity modulated radiation treatment delivery (IMRT), includes guidance and	77386	Prior authorization is required.
tracking, when performed; complex		
Intensity modulated treatment delivery, single or multiple fields/arcs, via narrow spatially	G6015	Prior authorization is required.
and temporally modulated beams, binary,		
dynamic MLC, per treatment session Radiation Therapy	Codes	Prior Authorization Requirement
Radiation treatment management, 5	77427	Prior Authorization Requirement Prior authorization is required for conditions other than cancer.
treatments		·
Radiation therapy management with complete course of therapy consisting of 1 or 2	77431	Prior authorization is required for conditions other than cancer.
fractions only		
Stereotactic radiation treatment management of cranial lesion(s) (complete course of	77432	Prior authorization is required for conditions other than cancer.
treatment consisting of 1 session)		
Stereotactic body radiation therapy,	77435	Prior authorization is required for conditions other than cancer.
Stereotactic body radiation therapy, treatment management, per treatment course, to 1 or more lesions, including image	77435	Prior authorization is required for conditions other than cancer.
Stereotactic body radiation therapy, treatment management, per treatment course, to 1 or more lesions, including image guidance, entire course not to exceed 5	77435	Prior authorization is required for conditions other than cancer.
Stereotactic body radiation therapy, treatment management, per treatment course, to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions intraoperative radiation treatment	77435	Prior authorization is required for conditions other than cancer. Prior authorization is required for conditions other than cancer.
Stereotactic body radiation therapy, treatment management, per treatment course, to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions Intraoperative radiation treatment management	77469	Prior authorization is required for conditions other than cancer.
Stereotaclic body radiation therapy, treatment management, per treatment course, to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions intraoperative radiation treatment intraoperative radiation treatment Special treatment procedure (eg. total body urradiation, hemibody radiation, per oral or		
Stereotactic body radiation therapy, treatment management, per treatment course, to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions Intraoperative radiation treatment management Special treatment procedure (eg. total body irradiation, hemibody radiation, per oral or endocavitary irradiation)	77469 77470	Prior authorization is required for conditions other than cancer. Prior authorization is required for conditions other than cancer.
Stereotactic body radiation therapy, treatment management, per treatment accurse, to 1 or more lesions, including image quidance, entire course not to exceed 5 fractions. Intraoperative radiation treatment management Special treatment procedure (eg. total body irradiation, hembody radiation, per oral or endocavitary irradiation) Radiation treatment delivery, superficial and/or ortho voltage, per day	77469 77470 77401	Prior authorization is required for conditions other than cancer. Prior authorization is required for conditions other than cancer. Prior authorization is required for conditions other than cancer.
Stereotaclic body radiation therapy, treatment management, per treatment accurse, to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions intraoperative radiation treatment intraoperative radiation treatment Special treatment procedure (eg. total body irradiation, hemibody radiation, per oral or endocavitary tradiation). Radiation treatment delivery, superficial and/or ortho voltage, per day Radiation treatment delivery, superficial and/or ortho voltage, per day Radiation treatment delivery, so 1 MeV;	77469 77470	Prior authorization is required for conditions other than cancer. Prior authorization is required for conditions other than cancer.
Stereotacile body radiation therapy, treatment management, per treatment anapement, to treatment management, to treatment anapement, or treatment course, to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions intraoperative adiation treatment. Special treatment procedure (eg., total body irradiation, hemibody radiation, per oral or endocavitary irradiation). Radiation treatment delivery, superficial and/or ortho voltage, per day Radiation treatment delivery, \Rightarrow 1 MeV; simple Radiation treatment delivery, \Rightarrow 1 MeV;	77469 77470 77401	Prior authorization is required for conditions other than cancer. Prior authorization is required for conditions other than cancer. Prior authorization is required for conditions other than cancer.
Stereotaclic body radiation therapy, treatment management, per treatment course, to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions intraoperative radiation treatment management. Special treatment procedure (eg., total body irradiation, hermbody radiation, per oral or endocavitary irradiation). Radiation treatment delivery, superficial and/or ortho voltage, per day Radiation treatment delivery, >> 1 MeV; simple Radiation treatment delivery, >> 1 MeV; theremediate	77469 77470 77401 77402 77407	Prior authorization is required for conditions other than cancer. Prior authorization is required for conditions other than cancer. Prior authorization is required for conditions other than cancer. Prior authorization is required for conditions other than cancer. Prior authorization is required for conditions other than cancer.
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Stereotaclic body radiation therapy, treatment management, per treatment course, to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions intraoperative radiation treatment intraoperative radiation treatment Special treatment procedure (eg. total body irradiation, hemibody radiation, per oral or endocavitary irradiation). Radiation treatment delivery, superficial and/or ortho voltage, per day Radiation treatment delivery, superficial and/or ortho voltage, per day Radiation treatment delivery, simple Radiation treatment delivery, so 1 MeV; simple Radiation treatment delivery, so 1 MeV; corrolex Therapeutic radiology port image(s) Guidance for localization of target volume for delivery of radiation treatment, includes interfaction treaking, when performed	77469 77470 77401 77402 77407 77412 77417 77387	Prior authorization is required for conditions other than cancer. Prior authorization is required for conditions other than cancer. Prior authorization is required for conditions other than cancer. Prior authorization is required for conditions other than cancer. Prior authorization is required for conditions other than cancer. Prior authorization is required for conditions other than cancer. Prior authorization is required for conditions other than cancer. Prior authorization is required for conditions other than cancer.
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Stereotaclic body radiation therapy, treatment management, per treatment accurse, to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions intraoperative radiation treatment. Special treatment procedure (eg. total body imalagement according to the procedure). According to the procedure (eg. total body imalagement according to the procedure). The procedure (eg. total body imalagement according to the procedure (eg. total body imalagement according to the procedure). The procedure (eg. total body imalagement according to the p	77469 77470 77401 77402 77407 77412 77417 77387	Prior authorization is required for conditions other than cancer. Prior authorization is required for conditions other than cancer. Prior authorization is required for conditions other than cancer. Prior authorization is required for conditions other than cancer. Prior authorization is required for conditions other than cancer. Prior authorization is required for conditions other than cancer. Prior authorization is required for conditions other than cancer. Prior authorization is required for conditions other than cancer.
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Stereotactic body radiation therapy, treatment management, per treatment anagement, per treatment anagement, per treatment anagement, per treatment anagement, per treatment anagement and the exceed 5 tractions. Intraoperative radiation treatment management procedure (eg. total body irradiation, hembody radiation, per oral or andocavitary irradiation). Radiation treatment delivery, superficial and/or ortho voltage, per day. Radiation treatment delivery, superficial and/or ortho voltage, per day. Radiation treatment delivery, superficial and/or ortho voltage, per day. Radiation treatment delivery, superficial and/or ortho voltage, per day. Radiation treatment delivery, superficial and/or ortho voltage, per day. Radiation treatment delivery, superficial results of the per delivery of management delivery. Radiation treatment delivery, superficial results of the per delivery of radiation treatment, includes intraffaction tracking, when performed High energy neutron radiation treatment delivery, 1 or more isocenter(s) with coplanar or non-coplanar geometry with blocking and/or wedge, and/or compensator(s) intraoperative radiation treatment delivery, x-ray, single treatment session intraoperative radiation treatment delivery, single treatment session intraoperative radiation source application; intermediate intracavitary radiation source application; complex, includes supervision, handling, baading of radiation source, when performed insertion of a vaginal radiation afterloading learning in effective and resulting intermediate.	77469 77470 77401 77402 77407 77412 77417 77387 77423 77424 77425 77761 77762	Prior authorization is required for conditions other than cancer. Prior authorization is required for conditions other than cancer. Prior authorization is required for conditions other than cancer. Prior authorization is required for conditions other than cancer. Prior authorization is required for conditions other than cancer. Prior authorization is required for conditions other than cancer. Prior authorization is required for conditions other than cancer. Prior authorization is required for conditions other than cancer. Prior authorization is required for conditions other than cancer. Prior authorization is required for conditions other than cancer. Prior authorization is required for conditions other than cancer. Prior authorization is required for conditions other than cancer. Prior authorization is required for conditions other than cancer. Prior authorization is required for conditions other than cancer. Prior authorization is required for conditions other than cancer. Prior authorization is required for conditions other than cancer.
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Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1	77372	Prior authorization is required for conditions other than cancer.
session; linear accelerator based		
Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more	77373	Prior authorization is required for conditions other than cancer.
lesions, including image guidance, entire course not to exceed 5 fractions		
Unlisted procedure, medical radiation physics, dosimetry and treatment devices,	77399	Prior authorization is required for conditions other than cancer.
and special services Ultrasonic guidance for placement of radiation therapy fields	G6001	Prior authorization is required for conditions other than cancer.
Stereoscopic x-ray guidance for localization of target volume for the delivery of radiation	G6002	Prior authorization is required for conditions other than cancer.
therapy Radiation treatment delivery, single treatment	G6003	Prior authorization is required for conditions other than cancer.
area, single port or parallel opposed ports, simple blocks or no blocks: up to 5 mev	3333	The deficit action is equited to conditions other than current.
Radiation treatment delivery, single treatment	66004	Prior authorization is required for conditions other than cancer.
area, single port or parallel opposed ports, simple blocks or no blocks: 6-10 mev	60004	
Radiation treatment delivery, single treatment area, single port or parallel opposed ports,	G6005	Prior authorization is required for conditions other than cancer.
simple blocks or no blocks: 11-19 mev		
Radiation treatment delivery, single treatment area, single port or parallel opposed ports,	G6006	Prior authorization is required for conditions other than cancer.
simple blocks or no blocks: 20 mev or greater	55007	Daire with scientist is a second for a distinct that the
Radiation treatment delivery, two separate treatment areas, three or more ports on a	G6007	Prior authorization is required for conditions other than cancer.
single treatment area, use of multiple blocks: up to 5 mev Radiation treatment delivery, two separate	account to the country of the countr	
treatment areas, three or more ports on a single treatment area, use of multiple blocks:	G6008	Prior authorization is required for conditions other than cancer.
Radiation treatment delivery, two separate	G6009	Prior authorization is required for conditions other than cancer.
treatment areas, three or more ports on a single treatment area, use of multiple blocks: 11-19 mey		
Radiation treatment delivery, two separate treatment areas, three or more ports on a	G6010	Prior authorization is required for conditions other than cancer.
single treatment area, use of multiple blocks: 20 mev or greater		
Radiation treatment delivery, three or more separate treatment areas, custom blocking,	G6011	Prior authorization is required for conditions other than cancer.
tangential ports, wedges, rotational beam, compensators, electron beam; up to 5 mev		
Radiation treatment delivery, three or more separate treatment areas, custom blocking,	G6012	Prior authorization is required for conditions other than cancer.
tangential ports, wedges, rotational beam, compensators, electron beam; 6-10 mev		
Radiation treatment delivery, three or more separate treatment areas, custom blocking,	G6013	Prior authorization is required for conditions other than cancer.
tangential ports, wedges, rotational beam, compensators, electron beam; 11-19 mev		
Radiation treatment delivery, three or more separate treatment areas, custom blocking,	G6014	Prior authorization is required for conditions other than cancer.
tangential ports, wedges, rotational beam, compensators, electron beam; 20 mey or		
greater Compensator-based beam modulation	G6016	Prior authorization is required for conditions other than cancer.
treatment delivery of inverse planned treatment using three or more high resolution		·
(milled or cast) compensator, convergent beam modulated fields, per treatment session		
Intra-fraction localization and tracking of	G6017	Prior authorization is required for conditions other than cancer.
target or patient motion during delivery of radiation therapy (e.g., 3D positional tracking,		
gating, 3D surface tracking), each fraction of treatment		
Cosmetic Procedures Tattooing, intradermal introduction of	Codes	Prior Authorization Requirement
insoluble opaque pigments to correct color defects of skin, including micropigmentation;	11920	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met.
6.0 sq cm or less Tattooing, intradermal introduction of	11921	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria
insoluble opaque pigments to correct color defects of skin, including micropigmentation;	11921	must be met.
6.1 to 20.0 sq cm Tattooing, intradermal introduction of	11922	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria
insoluble opaque pigments to correct color defects of skin, including micropigmentation;		must be met.
each additional 20.0 sq cm, or part thereof (List separately in addition to code for		
primary procedure) Subcutaneous injection of filling material (eg,	11950	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria
	1	must be met.
collagen); 1 cc or less	11951	
collagen); 1 cc or less Subcutaneous injection of filling material (eg, collagen); 1.1 to 5.0 cc	11951	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met.
collagen); 1 cc or less Subcutaneous injection of filling material (eg, collagen); 1.1 to 5.0 cc Subcutaneous injection of filling material (eg, collagen); 5.1 to 10.0 cc	11952	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met. Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met.
collagen); 1 cc or less Subcutaneous injection of filling material (eg, collagen); 1.1 to 5.0 cc Subcutaneous injection of filling material (eg, collagen); 5.1 to 10.0 cc		Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met. Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria
collagen): 1 cc or less Subcutaneous injection of filling material (eg. collagen): 1.1 to 5.0 cc Subcutaneous injection of filling material (eg. collagen): 5.1 to 10.0 cc Subcutaneous injection of filling material (eg. collagen): over 10.0 cc Implantation of biologic implant (eg. acellular Implantation of biologic implant (eg. acellular	11952	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met. Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met. Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met. Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met.
collagen); 1 cc or less Subcutaneous injection of filling material (eg, collagen); 1.1 to 5.0 cc Subcutaneous injection of filling material (eg, collagen); 5.1 to 10.0 cc Subcutaneous injection of filling material (eg, collagen); over 10.0 cc	11952 11954	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met. Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met. Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met.
collagen): 1 cc or less Subcutaneous injection of filling material (eg. collagen): 1.1 to 5.0 cc Subcutaneous injection of filling material (eg. collagen): 5.1 to 1.0. oc Subcutaneous injection of filling material (eg. collagen): 0.0 cc Implantation of biologic implant (eg. collagen), over 10.0 cc Implantation of biologic implant (eg. acellular dermal matrix) for soft tissue reinforcement (ie, breast, trunk) (List separately in addition	11952 11954	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met. Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met. Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met. Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met.
collagen); 1 cc or less Subcutaneous injection of filling material (eg. collagen); 1.1 to 5.0 cc Subcutaneous injection of filling material (eg. collagen); 5.1 to 10.0 cc Subcutaneous injection of filling material (eg. collagen); cver 10.0 cc Implantation of biologic implant (eg. acelular dermai matrix) for soft tissue reinforcement (ie, breast, trunk) (List separately in addition to code for primary procedure)	11952 11954 15777	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met. Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met. Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met. Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met. Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met.
collagen): 1 cc or less Subcutaneous injection of filling material (eg. collagen): 1.1 to 5.0 cc Subcutaneous injection of filling material (eg. collagen): 5.1 to 1.0 cc Subcutaneous injection of filling material (eg. collagen): cer 1.0 cc Implantation of biologic implant (eg. aceillular dermai matrix) for soft tissue reinforcement (ep. breast, trunk) (Lat separately in addition to code for primary procedure) Blepharoplasty, lower eyelid; Blepharoplasty, lower eyelid; with extensive	11952 11954 15777 15820	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met. Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met. Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met. Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met. Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met. Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met. Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met.
collagen); 1 cc or less Subcutaneous injection of filling material (eg. collagen); 1.1 to 5.0 cc Subcutaneous injection of filling material (eg. collagen); 5.1 to 1.0.0 cc Subcutaneous injection of filling material (eg. collagen); over 10.0 cc Subcutaneous injection of filling material (eg. collagen); over 10.0 cc Implantation of biologic implant (eg. acellular dermal matrix) for soft tissue reinforcement (le, breast, trunk) (lust separately in addition to code for primary procedure) Blepharoplasty, lower eyelid; Blepharoplasty, lower eyelid; Blepharoplasty, upper eyelid; Blepharoplasty, upper eyelid; Blepharoplasty, upper eyelid; Blepharoplasty, upper eyelid; with excessive	11952 11954 15777 15820	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met. Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met. Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met. Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met. Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met. Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met. Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met. Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met. Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met.
collagen): 1 cc or less Subcutaneous injection of filling material (eg. collagen): 1.1 to 5.0 cc Subcutaneous injection of filling material (eg. collagen): 5.1 to 1.0 cc Subcutaneous injection of filling material (eg. collagen): cver 1.0 cc Implantation of biologic implant (eg. acellular dermal matrix) for soft tissue reinforcement (ec. breast, trunk) (List separately in addition to code for primary procedure) Blepharoplasty, lower eyelid; Blepharoplasty, upper eyelid; Blepharoplasty, upper eyelid; Blepharoplasty, upper eyelid; Blepharoplasty, upper eyelid; with excessive skin weighting down lid	11952 11954 15777 15820 15821 15822	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met. Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met. Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met. Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met. Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met. Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met. Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met. Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met.
collagen); 1 cc or less Subcutaneous injection of filling material (eg. collagen); 1.1 to 5.0 cc Subcutaneous injection of filling material (eg. collagen); 5.1 to 1.0.0 cc Subcutaneous injection of filling material (eg. collagen); over 10.0 cc Implantation of biloigoic implant (eg. acellular dermal matrix) for soft tissue reinforcement (le, breast, trunk) (lust separately in addition to code for primary procedure) Blepharoplasty, lower eyelici; Blepharoplasty, lower eyelici; Blepharoplasty, upper eyelid; Blepharoplasty, upper eyelid; Blepharoplasty, upper eyelid; Blepharoplasty, upper eyelid; Suction assisted lipectomy; trunk	11952 11954 15777 15820 15821 15822 15823	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met. Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met. Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met. Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met. Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met. Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met. Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met. Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met. Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met.
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collagen); 1 cc or less Subcutaneous injection of filling material (eg. collagen); 1.1 to 5.0 cc Subcutaneous injection of filling material (eg. collagen); 1.1 to 5.0 cc Subcutaneous injection of filling material (eg. collagen); 5.1 to 10.0 cc Subcutaneous injection of filling material (eg. collagen); over 10.0 cs Implantation of biologic implant (eg. acellular dermal matrix) for soft tissue reinforcement (e, breast, trunk) (List separately in addition to code for primary procedure) Blepharoplasty, lower eyelid; Blepharoplasty, lower eyelid; with extensive hermiated fat pad Blepharoplasty, upper eyelid; Blepharoplasty, upper eyelid; Suction assisted lipectomy; trunk Suction assisted lipectomy; upper extremity	11952 11954 15777 15820 15821 15822 15823 15877	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met. Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met. Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met. Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met. Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met. Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met. Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met. Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met. Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met. Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met. Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met. Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met.

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Breast reduction	19318	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met.
Breast augmentation with implant	19325	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met.
Removal of intact breast implant	19328	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria
Removal of ruptured breast implant, including	19330	must be met. Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria
implant contents (eg, saline, silicone gel)		must be met.
Insertion of breast implant on same day of mastectomy (ie, immediate)	19340	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met.
Insertion or replacement of breast implant on separate day from mastectomy	19342	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met.
Nipple/areola reconstruction	19350	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met.
Correction of inverted nipples	19355	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met.
Tissue expander placement in breast reconstruction, including subsequent	19357	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria
expansion(s) Breast reconstruction; with latissimus dorsi	19361	must be met. Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria
flap Breast reconstruction; with free flap (eg,	19364	must be met. Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria
fTRAM, DIEP, SIEA, GAP flap)		must be met.
Breast reconstruction; with single-pedicled transverse rectus abdominis myocutaneous (TRAM) flap	19367	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met.
Breast reconstruction; with single-pedicled transverse rectus abdominis myocutaneous	19368	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met.
(TRAM) flap, requiring separate microvascular anastomosis (supercharging)		must be met.
Breast reconstruction; with bipedicled transverse rectus abdominis myocutaneous	19369	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met.
(TRAM) flap Revision of peri-implant capsule, breast,	19370	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria
including capsulotomy, capsulorrhaphy, and/or partial capsuloctomy	10374	must be met.
Peri-implant capsulectomy, breast, complete, including removal of all intracapsular contents	19371	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met.
Revision of reconstructed breast (eg, significant removal of tissue, re-advancement	19380	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met.
and/or re-inset of flaps in autologous reconstruction or significant capsular revision		mus de mes.
combined with soft tissue excision in implant- based reconstruction)		
Preparation of moulage for custom breast implant	19396	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met.
Unlisted procedure, breast	19499	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met.
Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip	30400	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met.
Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar	30410	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria
cartilages, and/or elevation of nasal tip Rhinoplasty, primary; including major septal	30420	must be met. Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria
repair Rhinoplasty, secondary; minor revision (small		must be met.
amount of nasal tip work)		Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met.
Rhinoplasty, secondary; intermediate revision (bony work with osteotomies)		Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met.
Rhinoplasty, secondary; major revision (nasal tip work and osteotomies)	30450	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met.
Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including	30460	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met.
columellar lengthening; tip only Rhinoplasty for nasal deformity secondary to	30462	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria
congenital cleft lip and/or palate, including columellar lengthening; tip, septum, osteotomies		must be met.
Repair of nasal vestibular stenosis (eg, spreader grafting, lateral nasal wall	30465	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met.
reconstruction) Repair of nasal valve collapse with	30468	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria
subcutaneous/submucosal lateral wall implant(s)		must be met.
Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft	30520	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met.
replacement with graft Repair choanal atresia; intranasal	30540	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria
Repair choanal atresia; transpalatine	30545	must be met. Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria
Lysis intranasal synechia	30560	must be met. Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria
Repair fistula; oromaxillary (combine with	30580	must be met. Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria
31030 if antrotomy is included) Repair fistula; oronasal	30600	must be met. Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria
Septal or other intranasal dermatoplasty	30620	must be met. Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria
(does not include obtaining graft)		must be met.
Repair nasal septal perforations	30630	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met.
Prosthesis, breast (implantable)	C1789	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met.
Injection, onabotulinumtoxinA, 1 unit	J0585	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met.
Injection, abobotulinumtoxinA, 5 units	J0586	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met.
Injection, rimabotulinumtoxinB, 100 units	J0587	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria
Injection, incobotulinumtoxinA, 1 unit	J0588	must be met. Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria
Implantable breast prosthesis, silicone or	L8600	must be met. Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria
equal Punch graft for hair transplant; 1 to 15 punch	15775	must be met. Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria
grafts Punch graft for hair transplant; more than 15	15776	must be met. Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria
punch grafts Dermabrasion; total face (eg, for acne		must be met.
Dermabrasion; total face (eg, for acne scarring, fine wrinkling, rhytids, general keratosis)	15780	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met.
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Dermabrasion; segmental, face	15781	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met.
Dermabrasion; regional, other than face	15782	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met.
Dermabrasion; superficial, any site (eg. tattoo	15783	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria
removal) Abrasion; single lesion (eg, keratosis, scar)	15786	must be met. Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria
Abrasion; each additional 4 lesions or less	15787	must be met.
(List separately in addition to code for primary procedure)	15/8/	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met.
Chemical peel, facial; epidermal	15788	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria
Chemical peel, facial; dermal	15789	must be met. Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria
Chemical peel, nonfacial; epidermal	15792	must be met. Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria
	15793	must be met.
Chemical peel, nonfacial; dermal		Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met.
Cervicoplasty	15819	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met.
Rhytidectomy; forehead	15824	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met.
Rhytidectomy; neck with platysmal tightening	15825	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria
(platysmal flap, P-flap) Rhytidectomy; glabellar frown lines	15826	must be met. Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria
Rhytidectomy; cheek, chin, and neck	15828	must be met. Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria
		must be met.
Rhytidectomy; superficial musculoaponeurotic system (SMAS) flap	15829	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met.
Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen,	15830	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met.
infraumbilical panniculectomy Excision, excessive skin and subcutaneous	15832	must be met. Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria
tissue (includes lipectomy); thigh		must be met.
Excision, excessive skin and subcutaneous tissue (includes lipectomy); leg	15833	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met.
Excision, excessive skin and subcutaneous tissue (includes lipectomy); hip	15834	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met.
Excision, excessive skin and subcutaneous tissue (includes lipectomy); buttock	15835	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria
Excision, excessive skin and subcutaneous	15836	must be met. Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria
tissue (includes lipectomy); arm Excision, excessive skin and subcutaneous	15837	must be met. Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria
tissue (includes lipectomy); forearm or hand		must be met.
Excision, excessive skin and subcutaneous tissue (includes lipectomy); submental fat pad	15838	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met.
Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area	15839	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met.
Laser in situ keratomileusis (LASIK)	50800	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria
Photorefractive keratectomy (PRK)	50810	must be met. Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria
Photorefractive keratectomy (PRK) Mental Health and Substance Abuse	S0810 Codes	
Mental Health and Substance Abuse Inpatient 18+	Codes	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met. Prior Authorization Requirement
Mental Health and Substance Abuse Inpatient 18+ Alcohol and/or other drug treatment program, per diem	Codes H2036	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met. Prior Authorization Requirement A prior authorization is required. Members must be 18 and older, with a behavioral health diagnosis.
Mental Health and Substance Abuse Inpatient 18+ Alcohol and/or other drug treatment program, per diem Alcohol and/or drug abuse halfway house services, per diem	Codes H2036 H2034	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met. Prior Authorization Requirement A prior authorization is required. Members must be 18 and older, with a behavioral health diagnosis. A prior authorization is required. Members must be 18 and older, with a behavioral health diagnosis.
Mental Health and Substance Abuse Inpatient 18+ Alcohol and/or other drug treatment program, per diem Alcohol and/or other drug treatment program, services, per diem Mental Health and Substance Use Partial Hospitalization	Codes	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met. Prior Authorization Requirement A prior authorization is required. Members must be 18 and older, with a behavioral health diagnosis. A prior Authorization is required. Members must be 18 and older, with a behavioral health diagnosis. Prior Authorization Requirement
Mental Health and Substance Abuse Inpatient 18+ Alcohol and/or other drug treatment program, per diem Alcohol and/or drug abuse halfway house services, per diem Mental Health and Substance Use Partial Hospitalization Mental health partial hospitalization, treatment, less than 24 hours	Codes H2036 H2034 Codes H0035	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met. Prior Authorization Requirement A prior authorization is required. Members must be 18 and older, with a behavioral health diagnosis. A prior authorization is required. Members must be 18 and older, with a behavioral health diagnosis. Prior Authorization Requirement A prior authorization is required. Members must have a behavorial health diagnosis.
Mental Health and Substance Abuse Inpatient 18+ Alcohol and/or other drug treatment program, per diem Alcohol and/or oftug abuse halfway house services, per diem Mental Health and Substance Use Partial Hospitalization Mental health partial hospitalization,	Codes	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met. Prior Authorization Requirement A prior authorization is required. Members must be 18 and older, with a behavioral health diagnosis. A prior Authorization is required. Members must be 18 and older, with a behavioral health diagnosis. Prior Authorization Requirement
Mental Health and Substance Abuse Inpatient 18+ Alcohol and/or other drug treatment program, per diem Alcohol and/or drug abuse halfway house services, per diem Mental Health and Substance Use Partial Hospitalization Mental health partial hospitalization, treatment, less than 24 hours Substance Abuse intensive Outpatient	Codes H2036 H2034 Codes H0035	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met. Prior Authorization Requirement A prior authorization is required. Members must be 18 and older, with a behavioral health diagnosis. A prior authorization is required. Members must be 18 and older, with a behavioral health diagnosis. Prior Authorization Requirement A prior authorization is required. Members must have a behavorial health diagnosis.
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Closed treatment of temporomandibular	21480	Prior authorization is required.
dislocation; initial or subsequent Closed treatment of temporomandibular	21485	Prior authorization is required.
dislocation; complicated (eg, recurrent		. nor sacronzación is required.
requiring intermaxillary fixation or splinting),		
initial or subsequent Open treatment of temporomandibular	21490	Prior authorization is required.
dislocation		
Arthroscopy, temporomandibular joint, diagnostic, with or without synovial biopsy	29800	Prior authorization is required.
(separate procedure)		
Arthroscopy, temporomandibular joint,	29804	Prior authorization is required.
surgical Vagus Nerve Stimulation	Codes	Prior Authorization Requirement
Vagotomy including pyloroplasty, with or	43640	Prior authorization is required.
without gastrostomy; truncal or selective	45040	The decientation of equities.
Vagotomy including pyloroplasty, with or without gastrostomy; parietal cell (highly	43641	Prior authorization is required.
selective)		
Laparoscopy, surgical; transection of vagus	43651	Prior authorization is required.
nerves, truncal Laparoscopy, surgical; transection of vagus	Ancra	A Constitution of the Cons
nerves, selective or highly selective	43652	Prior authorization is required.
Injection(s), anesthetic agent(s) and/or	64408	Prior authorization is required.
steroid; vagus nerve Open implantation of cranial nerve (eg, vagus	CARCO	A Secretaria Secretaria Sed
nerve) neurostimulator electrode array and	04308	Prior authorization is required.
pulse generator		
Revision or replacement of cranial nerve (eg, vagus nerve) neurostimulator electrode array,	64569	Prior authorization is required.
including connection to existing pulse		
generator		
Removal of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse	64570	Prior authorization is required.
generator		
Transection or avulsion of; vagus nerves	64755	Prior authorization is required.
limited to proximal stomach (selective proximal vagotomy, proximal gastric		
vagotomy, parietal cell vagotomy, supra- or		
highly selective vagotomy) Transection or avulsion of; vagus nerve	64760	Drier authorization is required
(vagotomy), abdominal	64760	Prior authorization is required.
Vagus nerve blocking therapy (morbid	0312T	Prior authorization is required.
obesity); laparoscopic implantation of neurostimulator electrode array, anterior and		
posterior vagal trunks adjacent to		
esophagogastric junction (EGJ), with		
implantation of pulse generator, includes programming		
Vagus nerve blocking therapy (morbid	0313T	Prior authorization is required.
obesity); laparoscopic revision or	03131	The decient of equilibria
replacement of vagal trunk neurostimulator		
electrode array, including connection to existing pulse generator		
Vagus nerve blocking therapy (morbid	0314T	Prior authorization is required.
obesity); laparoscopic removal of vagal trunk		
neurostimulator electrode array and pulse generator		
Vagus nerve blocking therapy (morbid	0315T	Prior authorization is required.
obesity); removal of pulse generator	02457	Dalay and be adventional to a service of
Vagus nerve blocking therapy (morbid	0316T	Prior authorization is required.
Vagus nerve blocking therapy (morbid obesity); replacement of pulse generator Vagus nerve blocking therapy (morbid	0316T	Prior authorization is required. Prior authorization is required.
Vagus nerve blocking therapy (morbid obesity); replacement of pulse generator Vagus nerve blocking therapy (morbid obesity); neurostimulator pulse generator		
Vagus nerve blocking therapy (morbid obesity); replacement of pulse generator Vagus nerve blocking therapy (morbid		
Vagus nerve blocking therapy (morbid obesity): replacement of pulse generator Vagus nerve blocking therapy (morbid obesity); neurostimulator pulse generator electronic analysis, includes reprogramming when performs	0317T Codes	
Vagus nerve blocking therapy (morbid obesity); replacement of pulse generator Vagus nerve blocking therapy (morbid obesity); neurostimulator pulse generator electronic analysis, includes reprogramming when performed Vein Procedures Endovenous ablation therapy of incompetent	0317T Codes	Prior authorization is required.
Vagus nerve blocking therapy (morbid obesity): replacement of pulse generator Vagus nerve blocking therapy (morbid obesity); neurostimulator pulse generator electronic analysis, includes reprogramming when performs	0317T Codes	Prior authorization is required. Prior Authorization Requirement
Vagus nerve blocking therapy (morbid obselty): negleament of pulse generator Vagus nerve blocking therapy (morbid obselty): neurostimulator pulse generator electronic analysis, includes reprogramming when performed Verin Procedures Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging	0317T Codes	Prior authorization is required. Prior Authorization Requirement
Vagus nerve blocking therapy (morbid obesity); regleament of pulse generator Vagus nerve blocking therapy (morbid obesity), neurostimulator pulse generator electronic analysis, includes reprogramming when performed Vein Procedures Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; first vein treated	0317T Codes 36473	Prior authorization is required. Prior Authorization Requirement Prior authorization is required.
Vagus nerve blocking therapy (morbid obesity); regleament of pulse generator Vagus nerve blocking therapy (morbid obesity), neurostimulator pulse generator electronic analysis, includes reprogramming when performed Vein Procedures Endovenous ablation therapy of incompetent vein, extremtly, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; first vein treated Endovenous ablation therapy of incompetent vein, extremtly, inclusive of all imaging vein, extremtly, inclusive of all imaging	0317T Codes 36473	Prior authorization is required. Prior Authorization Requirement
Vagus nerve blocking therapy (morbid obesity): regleament of pulse generator Vagus nerve blocking therapy (morbid obesity): neurostimulator pulse generator electronic analysis, includes reprogramming when performed values of the pulse of the procedures and the procedures and the procedures and the procedures and the procedures are the procedures and the procedures and the procedures are the	0317T Codes 36473	Prior authorization is required. Prior Authorization Requirement Prior authorization is required.
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Vagus nerve blocking therapy (morbid obesity); regleament of pulse generator Vagus nerve blocking therapy (morbid obesity); neurostimulator pulse generator electronic analysis, includes reprogramming when performed Velin Procedures Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; first vein treated endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; subsequent violity (section of all imaging guidance and monitoring, percutaneous, mechanochemical; subsequent violity) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)	0317T Codes 36473	Prior authorization is required. Prior Authorization Requirement Prior authorization is required. Prior authorization is required.
Vagus nerve blocking therapy (morbid obselty): regleament of pulse generator Vagus nerve blocking therapy (morbid obselty): neurostimulator pulse generator electronic analysis, includes reprogramming when performed Verin Procedures Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; first vein treated 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) Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging upone.	0317T Codes 36473	Prior authorization is required. Prior Authorization Requirement Prior authorization is required.
Vagus nerve blocking therapy (morbid obesity); regleament of pulse generator Vagus nerve blocking therapy (morbid obesity); neurostimulator pulse generator electronic analysis, includes reprogramming when performed values are programming when performed values are programming when performed values are programming under a construction of the procedures. Endovenous ablation therapy of incompetent vein, extremtly, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; first vein treated Endovenous ablation therapy of incompetent vein, extremtly, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; subsequent vein(s) treated in a single extremtly, each through separate access sites (List separately in addition to code for primary procedure) Endovenous ablation therapy of incompetent vein, extremtly, inclusive of all imaging guidance and monitoring, percutaneous,	0317T Codes 36473	Prior authorization is required. Prior Authorization Requirement Prior authorization is required. Prior authorization is required.
Vagus nerve blocking therapy (morbid obselty): regleament of pulse generator Vagus nerve blocking therapy (morbid obselty): neurostimulator pulse generator electronic analysis, includes reprogramming when performed Verin Procedures Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; first vein treated 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) Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging upone.	0317T Codes 36473	Prior authorization is required. Prior Authorization Requirement Prior authorization is required. Prior authorization is required.
Vagus nerve blocking therapy (morbid obesity); reglenement of pulse generator Vagus nerve blocking therapy (morbid obesity); neurostimulator pulse generator electronic analysis, includes reprogramming when performed. For exemple, includes reprogramming when performed values, returnity, inclusive of all imaging quidance and monitoring, percutaneous, mechanochemical; first vein treated endemonus ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; subsequent vein(e) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure). Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated.	0317T Codes 36473 36474	Prior authorization is required. Prior Authorization Requirement Prior authorization is required. Prior authorization is required.
Vagus nerve blocking therapy (morbid obesity); regleament of pulse generator Vagus nerve blocking therapy (morbid obesity); neurostimulator pulse generator electronic analysis, includes reprogramming when performed values per solution therapy of incompetent vein, extremtly, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; first vein treated Endovenous ablation therapy of incompetent vein, extremtly, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; subsequent vein(s) treated in a single extremtly, each through separate access sites (List separately in addition to code for primary procure). Endovenous ablation therapy of incompetent vein, extremtly, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated	0317T Codes 36473 36474	Prior authorization is required. Prior authorization is required. Prior authorization is required. Prior authorization is required.
Vagus nerve blocking therapy (morbid obesity); regleament of pulse generator Vagus nerve blocking therapy (morbid obesity); neurostimulator pulse generator electronic analysis, includes reprogramming when performed values per server	0317T Codes 36473 36474 36475	Prior authorization is required. Prior authorization is required. Prior authorization is required. Prior authorization is required.
Vagus nerve blocking therapy (morbid obesity); reglenement of pulse generator Vagus nerve blocking therapy (morbid obesity); neurostimulator pulse generator electronic analysis, includes reprogramming when performed. Procedures Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; first vein treated endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; subsequent vein(e) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure). Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated. Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, guidance and monitoring, percutaneous, laser, first vein treated	0317T Codes 36473 36474 36475	Prior authorization is required. Prior authorization is required. Prior authorization is required. Prior authorization is required.
Vagus nerve blocking therapy (morbid obesity); regleament of pulse generator Vagus nerve blocking therapy (morbid obesity); neurostimulator pulse generator electronic analysis, includes reprogramming when performed values are programming when performed values are programming when performed values are programming under and morbiding, percutaneous, mechanochemical; first vein treated Endovenous ablation therapy of incompetent value, extremity, inclusive of all imaging guidance and morbiding, percutaneous, mechanochemical; subsequent veln(s) treated in a single extremity, each through separate access sites (last separately in addition to code for primary procedure) Endovenous ablation therapy of incompetent value, extremity, inclusive of all imaging guidance and morbiding, percutaneous, radiofrequency; first vein treated Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and morbiding, percutaneous, radiofrequency; first vein treated Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and morbiding, percutaneous, laser, first vein treated Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging upidance and morbiding, percutaneous, laser, first vein treated	0317T Codes 36473 36474 36475	Prior authorization is required.
Vagus nerve blocking therapy (morbid obesity); regleament of pulse generator Vagus nerve blocking therapy (morbid obesity); neurostimulator pulse generator electronic analysis, includes reprogramming when performed values per solven performed values and performed values. Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; first vein treated 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) Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser, first vein treated Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser, first vein treated Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser, first vein treated	0317T Codes 36473 36474 36475	Prior authorization is required.
Vagus nerve blocking therapy (morbid obesity); reglenement of pulse generator Vagus nerve blocking therapy (morbid obesity); neurostimulator pulse generator electronic analysis, includes reprogramming when performed. For the procedures Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; first vein treated Endovenous ablation therapy of incompetent, evin, 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). Endovenous ablation therapy of incompetent, evin, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated 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	0317T Codes 36473 36474 36475	Prior authorization is required.
Vagus nerve blocking therapy (morbid obesity); regleament of pulse generator Vagus nerve blocking therapy (morbid obesity); neurostimulator pulse generator electronic analysis, includes reprogramming when performed values and process	0317T Codes 36473 36474 36475	Prior authorization is required.
Vagus nerve blocking therapy (morbid obesity); reglenement of pulse generator Vagus nerve blocking therapy (morbid obesity); neurostimulator pulse generator electronic analysis, includes reprogramming when performed. For the procedures Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; first vein treated Endovenous ablation therapy of incompetent, evin, 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). Endovenous ablation therapy of incompetent, evin, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated 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	0317T Codes 36473 36474 36475 36478	Prior authorization is required.
Vagus nerve blocking therapy (morbid obesity); reglenement of pulse generator Vagus nerve blocking therapy (morbid obesity); neurostimulator pulse generator electronic analysis, includes reprogramming when performed vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; first vein treated Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; first vein treated 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) Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, talorification, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated 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) Ligation and division of long saphenome vein as sphenofeman junction, or discussion.	0317T Codes 36473 36474 36475 36478	Prior authorization is required.
Vagus nerve blocking therapy (morbid obesity); reglacement of pulse generator Vagus nerve blocking therapy (morbid obesity); neurostimulator pulse generator electronic analysis, includes reprogramming when performed values and processing the processing state of the processing state of the processing state of all maging guidance and morbid processing, percutaneous, mechanochemical; first vein treated Endovenous ablation therapy of incompetent value, extremity, inclusive of all maging guidance and morbid processing, percutaneous, mechanochemical; subsequent vein(s) treated in a single extremity, enclusive of all maging guidance and morbid processing states of the p	0317T Codes 36473 36474 36475 36478 36479	Prior authorization is required.
Vagus nerve blocking therapy (morbid obesity); regleament of pulse generator Vagus nerve blocking therapy (morbid obesity); neurostimulator pulse generator electronic analysis, includes reprogramming when performed values and process	0317T Codes 36473 36474 36475 36478 36479 37700	Prior authorization is required.
Vagus nerve blocking therapy (morbid obesity); reglenement of pulse generator Vagus nerve blocking therapy (morbid obesity); neurostimulator pulse generator electronic analysis, includes reprogramming when performed vein, extremity, inclusive of all imaging quidance and monitoring, percutaneous, mechanochemical; first vein treated Endownous ablation therapy of incompetent vein, extremity, inclusive of all imaging quidance and monitoring, percutaneous, mechanochemical; first vein treated in the properties of the	0317T Codes 36473 36474 36475 36478 36479 37700	Prior authorization is required.
Vagus nerve blocking therapy (morbid obesity); regleament of pulse generator Vagus nerve blocking therapy (morbid obesity); neurostimulator pulse generator electronic analysis, includes reprogramming when performed values and process	0317T Codes 36473 36474 36475 36478 36479 37700	Prior authorization is required.
Vagus nerve blocking therapy (morbid obesity); reglement of pulse generator Vagus nerve blocking therapy (morbid obesity); neurostimulator pulse generator electronic analysis, includes reprogramming when performed values per server s	0317T Codes 36473 36474 36475 36478 36479 37700	Prior authorization is required.
Vagus nerve blocking therapy (morbid obesity); reglenement of pulse generator values nerve blocking therapy (morbid obesity); neurostimulator pulse generator electronic analysis, includes reprogramming when performed vein, extremity, inclusive of all imaging quidance and monitoring, percutaneous, mechanochemical; first vein treated Endownous ablation therapy of incompetent vein, extremity, inclusive of all imaging quidance and monitoring, percutaneous, mechanochemical; first vein treated in the properties of th	0317T Codes 36473 36474 36475 36478 36479 37700 37718 37722	Prior authorization is required.
Vagus nerve blocking therapy (morbid obesity); regleament of pulse generator Vagus nerve blocking therapy (morbid obesity); neurostimulator pulse generator electronic analysis, includes reprogramming when performed values per performed values and processing states	0317T Codes 36473 36474 36475 36478 36479 37700 37718 37722	Prior authorization is required.
Vagus nerve blocking therapy (morbid obesity); regleament of pulse generator Vagus nerve blocking therapy (morbid obesity); neurostimulator pulse generator electronic analysis, includes reprogramming when performed values processed in the procedures and control of the procedures. Endovenous ablation therapy of incompetent vain, extremity, inclusive of all imaging guidance and morbinity, percutaneous, mechanochemical; first vein treated Endovenous ablation therapy of incompetent vain, extremity, inclusive of all imaging guidance and morbinity, percutaneous, mechanochemical; subsequent vein(s) treated in a single extremity, exclusive of all imaging guidance and morbinity, percutaneous, mechanochemical; subsequent vein(s) treated in a single extremity, inclusive of all imaging guidance and morbinity, percutaneous, radiofrequency; first vein treated Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and morbinity, percutaneous, laser, first vein treated Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and morbinity, percutaneous, laser, first vein treated Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and morbinity, percutaneous, laser, first vein treated Endovenous ablation therapy of incompetent veine, extremity, inclusive of all imaging guidance and morbinity, percutaneous, laser, subsequent veine); treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure). Ligation, division, and stripping, short saphenous vein as saphenous vein some saphenous vein as saphenous vein with radical as competent veint of the part of the part of the p	0317T Codes 36473 36474 36475 36478 37700 37718 37722 37735	Prior authorization is required.
Vagus nerve blocking therapy (morbid obesity); reglenement of pulse generator Vagus nerve blocking therapy (morbid obesity); neurostimulator pulse generator electronic analysis, includes reprogramming when performed vein, extremity, inclusive of all imaging quidance and monitoring, percutaneous, mechanochemical; first vein treated Endownous ablation therapy of incompetent vein, extremity, inclusive of all imaging quidance and monitoring, percutaneous, mechanochemical; first vein treated in the control of the co	0317T Codes 36473 36474 36475 36478 36479 37700 37718 37722	Prior authorization is required.
Vagus nerve blocking therapy (morbid obesity); reglement of pulse generator Vagus nerve blocking therapy (morbid obesity); neurostimulator pulse generator electronic analysis, includes reprogramming when performed values per performed values and processing and processing states and control of the processing states and control of the processing states and control of all magging guidance and montoring, percutaneous, mechanochemical; first vein treated and control of all magging guidance and montoring, percutaneous, mechanochemical; subsequent vein(s) treated in a single extremity, inclusive of all magging guidance and montoring, percutaneous, mechanochemical; subsequent vein(s) treated in a single extremity, inclusive of all imagging guidance and montoring, percutaneous, radiofrequency; first vein treated. Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imagging guidance and montoring, percutaneous, radiofrequency; first vein treated. Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imagging guidance and montoring, percutaneous, laser, first vein treated. Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imagging guidance and montoring, percutaneous, laser, first vein treated. Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imagging guidance and montoring, percutaneous, laser, subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure). Ligation, division, and stripping, long (greater) saphenous vein as saphenofermoral junction to knee or below interruption of communicating veins of lower lag, with excision of deep fascia.	0317T Codes 36473 36474 36475 36478 37700 37718 37722 37735	Prior authorization is required.
Vagus nerve blocking therapy (morbid obesity); reglement of pulse generator Vagus nerve blocking therapy (morbid obesity); neurostimulator pulse generator electronic analysis, includes reprogramming when performed values and processing the processing state of the processing state of all maging guidance and morbid processing, percutaneous, mechanochemical; first vein treated. Endovenous ablation therapy of incompetent vain, extremity, inclusive of all maging guidance and morbid processing, percutaneous, mechanochemical; first vein treateous, mechanochemical; subsequent vein(s) treated in a single extremity, exclusive of all imaging guidance and morbid processing states of the processing states and states and of the processing states and states and of the proces	0317T Codes 36473 36474 36475 36478 37700 37718 37722 37735	Prior authorization is required.
Vagus nerve blocking therapy (morbid obesity); reglenement of pulse generator Vagus nerve blocking therapy (morbid obesity); neurostimulator pulse generator electronic analysis, includes reprogramming when performed vein, extremity, inclusive of all imaging quidance and monitoring, percutaneous, mechanochemical; first vein treated Endownous ablation therapy of incompetent vein, extremity, inclusive of all imaging quidance and monitoring, percutaneous, mechanochemical; first vein treated endownous ablation therapy of incompetent vein, extremity, inclusive of all imaging quidance 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). Endownous ablation therapy of incompetent vein, extremity, inclusive of all imaging quidance and monitoring, percutaneous, radiofrequency; first vein treated. Endownous ablation therapy of incompetent vein, extremity, inclusive of all imaging quidance and monitoring, percutaneous, laser, first vein treated. Endownous ablation therapy of incompetent vein, extremity, inclusive of all imaging quidance and monitoring, percutaneous, laser, first vein treated endownous ablation therapy of incompetent vein, extremity, inclusive of all imaging quidance and monitoring, percutaneous, laser, first vein treated endownous ablation therapy of incompetent vein, extremity, inclusive of all imaging quidance and monitoring, percutaneous, laser, subsequent vein(s) treated in a single extremity, each through separate size in a single extremity, each through separate size in a single extremity, each through separate in a single extremity, each through separate in a single extremity, each formation in the extremity and intervention of committen in the extremity and intervention of ever	Codes 36473 36474 36475 36478 36479 37700 37718 37722 37735	Prior authorization is required.
Vagus nerve blocking therapy (morbid obesity); reglement of pulse generator Vagus nerve blocking therapy (morbid obesity); neurostimulator pulse generator electronic analysis, includes reprogramming when performed values and processing the processing stream of the proces	0317T Codes 36473 36473 36474 36475 36478 37700 37718 37722 37735 37760 37761	Prior authorization is required.
Vagus nerve blocking therapy (morbid obesity); reglement of pulse generator Vagus nerve blocking therapy (morbid obesity); neurostimulator pulse generator electronic analysis, includes reprogramming when performed values and processing the processing state of the processing state of the processing state of the processing state of all maging guidance and morbidries, percutaneous, mechanochemical; first vein treated Endovenous ablation therapy of incompetent value, extremity, inclusive of all maging guidance and morbidries, percutaneous, mechanochemical; subsequent vein(s) treated in a single extremity, and through separate access sites (List separately in addition to code for primary procedure) Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and morbidries, percutaneous, radiofrequency; first vein treated Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and morbidries, percutaneous, laser, first vein treated Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and morbidries, percutaneous, laser, first vein treated Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and morbidries, percutaneous, laser, first vein treated Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and morbidries, percutaneous, laser, subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure) Ligation, division, and stripping, long (greater) sephenous vein at saphenous vein at saphenofermoral junction to knee or below lugation of perforator veines, subfascial, open, including skind graft, when performed, lopen, lies Ligation of perforator veines, subfascial, open, including skind graft, when performed, logen, lies of subservations, of colors and skin graft and correct ments.	0317T Codes 36473 36473 36474 36475 36478 37700 37718 37722 37735 37760 37761 37765	Prior authorization is required.
Vagus nerve blocking therapy (morbid obesity); reglenement of pulse generator values nerve blocking therapy (morbid obesity); neurostimulator pulse generator electronic analysis, includes reprogramming when performed with procedures Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging quidance and monitoring, percutaneous, mechanochemical; first vein treated Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging quidance 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). Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, respectively, inclusive of all imaging guidance and monitoring, percutaneous, addiferequency; first vein treated Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser, first vein treated endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser, first vein treated endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser, first vein treated 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). Ligation and division, and stripping, short saphenous vein as aphenofemoral inclusion, or distal integration of veine and skin graft and/or interruption of communicating veins of lower lag, with excision of deep fascial Ligation of perforator veins, subfascial, radical (Linton type), including skin graft, when performed, end, end, ellegition of perforator veins, subfascial, radical (Linton type), i	0317T Codes 36473 36473 36474 36475 36478 37700 37718 37722 37735 37760 37761	Prior authorization is required.
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Injection, emapalumab-lzsg, 1 mg 19210 Prior Authorization is required.
Injection, emicizumab-kxwh, 0.5 mg J7170 Prior Authorization is required. Injection, eposetin alfa, (for non-esrd use) J0885 Prior Authorization is required.
Injection, epoetin alfa, (for non-esrd use) J0885 Prior Authorization is required.
Loos units Injection, popetin alfa, 100 units (for esrd on Q4081 Prior Authorization is required.
dialysis)
Injection, epoetin alfa, (for non-esrd use), 10885 Prior Authorization is required.
1000 units Injection, epoetin alfa, 100 units (for esrd on Q4081 Prior Authorization is required.
Injection, epoemaria, audumis (roresto on dauge) (4405) Prior Authorization is required.
Injection, epoetin beta, 1 microgram, (for esrd 10887 Prior Authorization is required.
on dialysis)
Injection, epoetin beta, 1 microgram, (for non exercise) 1988 Prior Authorization is required.
esra use
Injection, epipotosensi, v. 3-ng 12323 informations around in English (injection, epipotosensi, v. 3-ng 1332 informations around in English (injection, epipotosensi, v. 3-ng 1332 information is required.
Esketamine, nasal spray, 1 mg S0013 Prior Authorization is required.
Injection, eteplirsen, 10 mg J1428 Prior Authorization is required.
Injection, eteplisen, 10 mg J1428 Prior Authorization is required. Injection, evinacumab-dgnb, 5 mg J1305 Prior Authorization is required.
Injection, evinacumab-dgnb, 5 mg J1305 Prior Authorization is required.
Injection, evinacumab-dgnb, 5 mg J1305 Prior Authorization is required. Factor viii (antihemophilic factor, recombinant) J7192 Prior Authorization is required.
Injection, evinacumab-dgnb, 5 mg J1305 Prior Authorization is required. Factor viii (antihemophilic factor, recombinant) J7192 Prior Authorization is required. per Lu., not otherwise specified Injection, ferric carboxymaltose, 1 mg J1439 Prior Authorization is required.
Injection, evinacumab-dgnb, 5 mg J1305 Prior Authorization is required. Factor viii (antihemophilic factor, recombinant) per Lu., not otherwise specified Injection, ferric carbonymaktose, 1 mg J1439 Prior Authorization is required. Prior Authorization is required. Injection, ferric carbonymaktose, 1 mg J1439 Prior Authorization is required.
Injection, evinacumab-dgnb, 5 mg J1305 Prior Authorization is required. Factor viii (anthemophilic factor, recombinant) J7192 Prior Authorization is required. per Lu., not otherwise specified Injection, ferric carboxymaltose, 1 mg J1439 Prior Authorization is required. Injection, ferumosytol, for treatment of iron deficiency anemia, 1 mg (non-exf use) Prior Authorization is required.
Injection, evinacumab-dgnb, 5 mg J1305 Prior Authorization is required. Factor viii (antihemophilic factor, recombinant) J7192 Prior Authorization is required. Prior Authorization is required. Prior Authorization is required. Injection, feru achaowymalose, 1 mg J1439 Prior Authorization is required. Injection, ferumosytol, for treatment of iron deficiency anemia, 1 mg (non-eard use) Injection, fireting (est), excludes J1442 Prior Authorization is required.
Injection, evinacumab-dgnb, 5 mg J1305 Prior Authorization is required. Factor viii (anthemophilic factor, recombinant) J7192 Prior Authorization is required. per Lu., not otherwise specified Injection, ferric carboxymaltose, 1 mg J1439 Prior Authorization is required. Injection, ferumosytol, for treatment of iron deficiency anemia, 1 mg (non-exf use) Prior Authorization is required.
Injection, evinacumab-dgnb, 5 mg J1305 Prior Authorization is required. Factor viii (antihemophilic factor, recombinant) per Lu., not otherwise specified Injection, ferric carbonymaltose, 1 mg Injection, foreit mg Injec
Injection, evinacumab-dgnb, 5 mg 11305 Prior Authorization is required. Factor viii (antihemophilic factor, recombinant) 17192 Prior Authorization is required. Injection, fernic carboxymaltose, 1 mg 11439 Prior Authorization is required. Injection, ferumonytol, for treatment of iron deficiency anemia, 1 mg (non-exrd use) Injection, filigrastin (g-csf), excludes Injection, filigrastin (g-csf), excludes Prior Authorization is required. Injection, filigrastin (g-csf), excludes Infection (prior Authorization is required. Injection, fondaparinux sodium, 0.5 mg 11652 Prior Authorization is required.

Injection, golimumab, 1 mg, for intravenous	J1602	Prior Authorization is required.
Injection, golodirsen, 10 mg	J1429	Prior Authorization is required.
Hyaluronan or derivative, euflexxa, for intra- articular injection, per dose	J7323	Prior Authorization is required.
Hyaluronan or derivative, gel-one, for intra-	J7326	Prior Authorization is required.
articular injection, per dose Hyaluronan or derivative, gelsyn-3, for intra-	J7328	Prior Authorization is required.
articular injection, 0.1 mg		·
Hyaluronan or derivitive, genvisc 850, for intra-articular injection, 1 mg	J7320	Prior Authorization is required.
Hyaluronan or derivative, hyalgan or supartz,	J7321	Prior Authorization is required.
for intra-articular injection, per dose Hyaluronan or derivative, monovisc, for intra-	J7327	Prior Authorization is required.
articular injection, per dose		
Hyaluronan or derivative, orthovisc, for intra- articular injection, per dose	J7324	Prior Authorization is required.
Injection, hydroxy progesterone caproate,	J1726	Prior Authorization is required.
(makena), 10 mg Hyaluronan or derivative, synvisc or synvisc-	J7325	Prior Authorization is required.
one, for intra-articular injection, 1 mg Injection, idursulfase, 1 mg	J1743	Daile A Abbaile in a single
Injection, indisulase, 1 mg Injection, imiglucerase, 10 units	11745	Prior Authorization is required. Prior Authorization is required.
Injection, immune globulin (bivigam), 500 mg	J1556	Prior Authorization is required.
Injection, immune globulin, (flebogamma/flebogamma dif), intravenous, non-lyophilized (e.g., liquid), 500 mg	J1572	Prior Authorization is required.
Injection, immune globulin, (gammagard liquid),	J1566	Prior Authorization is required.
non-lyophilized, (e.g., liquid), 500 mg Injection, immune globulin, (gammagard liquid),	11569	Prior Authorization is required.
non-lyophilized, (e.g., liquid), 500 mg		
Injection, immune globulin, (gamunex- c/gammaked), non-lyophilized (e.g., liquid), 500	J1561	Prior Authorization is required.
mg Injection, immune globulin, (gammaplex),	11557	Prior Authorization is required.
intravenous, non-lyophilized (e.g., liquid), 500	 -	
mg Injection, immune globulin (hizentra), 100 mg	11559	Prior Authorization is required.
Injection, immune globulin, (octagam),	J1568	Prior Authorization is required.
intravenous, non-lyophilized (e.g., liquid), 500		
Injection, immune globulin, intravenous, non-	J1554	Prior Authorization is required.
lyophilized (e.g., liquid), not otherwise specified, 500 mg		
Injection, immune globulin, intravenous, non-	11599	Prior Authorization is required.
lyophilized (e.g., liquid), not otherwise specified, 500 mg		
Injection, immune globulin (privigen),	J1459	Prior Authorization is required.
intravenous, non-lyophilized (e.g., liquid), 500 mg		
Injection, immune globulin/hyaluronidase,	J1575	Prior Authorization is required.
(hyqvia), 100 mg immune globulin Injection, incobotulinumtoxin a, 1 unit	10700	
	HIDSS	
Injection, inebilizumab-cdon, 1 mg	J0588 J1823	Prior Authorization is required. Prior Authorization is required.
Injection, inebilizumab-cdon, 1 mg Injection, infliximab, excludes biosimilar, 10 mg Injection, lanadelumab-flyo, 1 mg (code may	J1823	Prior Authorization is required.
Injection, inebilizumab-cdon, 1 mg Injection, infliximab, excludes biosimilar, 10 mg Injection, lanadelumab-fiyo, 1 mg (code may be used for medicare when drug administered	J1823 J1745	Prior Authorization is required. Prior Authorization is required.
Injection, inebilizumab-cdon, 1 mg Injection, infliximab, excludes biosimilar, 10 mg Injection, lanadelumab-flyo, 1 mg (code may be used for medicare when drug administered under direct supervision of a physician, not for use when drug is self- administered)	11823 11745 10593	Prior Authorization is required. Prior Authorization is required. Prior Authorization is required.
Injection, inebilizumab-cdon, 1 mg Injection, infliximab, excludes biosimilar, 10 mg Injection, lanadelumab-flyo, 1 mg (code may be used for medicare when drug, administered under direct supervision of a physician, not for use when drug is self- administered) Injection, lanoiidase, 0.1 mg	J1823 J1745 J0593	Prior Authorization is required. Prior Authorization is required. Prior Authorization is required. Prior Authorization is required.
Injection, inebilizumab-cdon, 1 mg Injection, infliximab, excludes biosimilar, 10 mg Injection, lanadelumab-flyo, 1 mg (code may be used for medicare when drug administered under direct supervision of a physician, not for use when drug is self- administered) injection, laronidase, 0.1 mg Leuprolide acetate (for depot suspension), 7.5 mg	J1823 J1745 J0593 J1931 J9217	Prior Authorization is required.
Injection, inebilizumab-cdon, 1 mg Injection, infloimab, excludes biosimilar, 10 mg Injection, lanadelumab-flyo, 1 mg (code may be used for medicare when drug administered under direct supervision of a physician, not for use when drug is self-administered) Injection, lanoidase, 0.1 mg Leuprolide acetate (for depot suspension), 7.5 mg Injection, leuprolide acetate (for depot Injection, leuprolide acetate (for depot	J1823 J1745 J0593	Prior Authorization is required. Prior Authorization is required. Prior Authorization is required. Prior Authorization is required.
Injection, inebilizumab-cdon, 1 mg Injection, infliximab, excludes biosimilar, 10 mg Injection, lanadelumab-flyo, 1 mg (code may be used for medicare when drug, administered under direct supervision of a physician, not for use when drug is self- administered) Injection, laronidase, 0.1 mg Leuprolide acetate (for depot suspension), 7.5 mg Injection, leuprolide acetate (for depot suspension), per 3.75 mg Injection, laronidase, 0.2 mg	J1823 J1745 J0593 J1931 J9217 J1950	Prior Authorization is required.
Injection, inebilizumab-cdon, 1 mg Injection, infloimab, excludes biosimilar, 10 mg Injection, lanadelumab-flyo, 1 mg (code may be used for medicare when drug administered under direct supervision of a physician, not for use when drug is self-administered) Injection, lanoldase, 0.1 mg Leuprolide acetate (for depot suspension), 7.5 mg Injection, leuprolide acetate (for depot suspension), per 3.75 mg Injection, luspatercept-aamt, 0.25 mg Injection, uspatercept-aamt, 0.25 mg Injection, uspatercept-aamt, 0.25 mg Injection, uspatercept-aamt, 0.25 mg	11823 11745 10593 11931 19217 11950 10896	Prior Authorization is required.
Injection, inebilizumab-cdon, 1 mg Injection, infliximab, excludes biosimilar, 10 mg Injection, lanadelumab-flyo, 1 mg (code may be used for medicare when drug, administered under direct supervision of a physician, not for use when drug is self- administered) Injection, laronidase, 0.1 mg Leuprolide acetate (for depot suspension), 7.5 mg Injection, leuprolide acetate (for depot suspension), per 3.75 mg Injection, laronidase, 0.2 mg	J1823 J1745 J0593 J1931 J9217 J1950	Prior Authorization is required.
Injection, inebilizumab-cdon, 1 mg Injection, infloimab, excludes biosimilar, 10 mg Injection, lanadelumab-flyo, 1 mg (code may be used for medicare when drug administered under direct supervision of a physician, not for use when drug is self-administered) Injection, lanolase, 0.1 mg Leuprolide acetate (for depot suspension), 7.5 mg Injection, leuprolide acetate (for depot suspension), per 3.75 mg Injection, luspatercept-aamt, 0.25 mg Injection, uspatercept-aamt, 0.25 mg Injection, mepolizumab, 1 mg Injection, methylnaltrexone, 0.1 mg Injection, natalizumab, 1 mg Injection, natalizumab, 1 mg Injection, nusinersen, 0.1 mg Injection, nusinersen, 0.1 mg	11823 11745 10593 11931 19217 11950 10896 12182 12212 12323	Prior Authorization is required.
Injection, inebilizumab-cdon, 1 mg Injection, infliximab, excludes biosimilar, 10 mg Injection, infliximab, excludes biosimilar, 10 mg Injection, lanadelumab-flyo, 1 mg (code may be used for medicare when drug administered under direct supervision of a physician, not for use when drug is self- administered) injection, lanonidase, 0.1 mg Leuprolide acetate (for depot suspension), 7.5 mg Injection, leuprolide acetate (for depot suspension), per 3. 7.5 mg Injection, mepolizumab, 1 mg Injection, mepolizumab, 1 mg Injection, natializumab, 1 mg Injection, nusinersen, 0.1 mg Injection, nusinersen, 0.1 mg Injection, nusinersen, 0.1 mg Injection, nusinersen, 0.1 mg Injection, ruspersen, 0.1 mg Injection, ruspersen, 0.1 mg Injection, ruspersen, 0.1 mg	J1823 J1745 J0593 J1931 J9217 J1950 J0896 J2182 J2212 J2323 J2326	Prior Authorization is required.
Injection, inebilizumab-cdon, 1 mg Injection, infloimab, excludes biosimilar, 10 mg Injection, lanadelumab-flyo, 1 mg (code may be used for medicare when drug administered under direct supervision of a physician, not for use when drug is self-administered) Injection, lanolase, 0.1 mg Leuprolide acetate (for depot suspension), 7.5 mg Injection, leuprolide acetate (for depot suspension), per 3.75 mg Injection, luspatercept-aamt, 0.25 mg Injection, uspatercept-aamt, 0.25 mg Injection, mempolizumab, 1 mg Injection, natalizumab, 1 mg Injection, oraelizumab, 1 mg Injection, oraelizumab, 1 mg Injection, oraelizumab, 1 mg Injection, oraelizumab, 5 mg Injection, mabulinumab, 5 mg Injection, mabulinumab, 5 mg Injection, mabulinumab, 5 mg Injection, mabulinumab, 5 mg	11823 11745 10593 11931 19217 11950 10896 12182 12212 12323 12326 12350	Prior Authorization is required.
Injection, inebilizumab. excludes biosimilar, 10 mg Injection, infliximab, excludes biosimilar, 10 mg Injection, lanadelumab-flyo, 1 mg (code may be used for mediciare when drug administered under direct supervision of a physician, not for use when drug is self- administered) injection, laronidase, 0.1 mg Leuprolide acetate (for depot suspension), 7.5 mg Injection, leuprolide acetate (for depot suspension), per 3.75 mg Injection, per 3.75 mg Injection, one polizumab, 1 mg Injection, mgopilizumab, 1 mg Injection, onatolizumab, 1 mg Injection, onatolizumab, 1 mg Injection, onatolizumab, 5 mg Injection, onatolizumab, 5 mg Injection, onatolizumab, 1 mg Injection, onatolizumab, 1 mg Injection, onatolizumab, 1 mg Injection, onatolizumab, 5 mg Injection, onatolizumab, 1 ng Injection, patsiran, 0.1 mg	11823 11745 10593 11931 19217 11950 10896 12182 12212 12323 12326 12350 12357	Prior Authorization is required.
Injection, inebilizumab-cdon, 1 mg Injection, infliximab, excludes biosimilar, 10 mg Injection, infliximab, excludes biosimilar, 10 mg Injection, lanadelumab-flyo, 1 mg (code may be used for medicare when drug administered under direct supervision of a physician, not for use when drug is self- administered) injection, laronidase, 0.1 mg Leuprolide acetate (for depot suspension), 7.5 mg Injection, leuprolide acetate (for depot suspension), per 3.75 mg Injection, hepspolitumab, 1 mg Injection, medicare, 10.1 mg Injection, nusinersen, 0.1 mg Injection, nusinersen, 0.1 mg Injection, orelizumab, 1 mg Injection, opatismab, 0.1 mg Injection, pagapamib sodium, 0.3 mg NOC drugs, other than inhabaltion drugs,	11823 11745 10593 11931 19217 11950 10896 12182 12212 12323 12326 12350	Prior Authorization is required.
Injection, inebilizumab-cdon, 1 mg Injection, infloimab, excludes biosimilar, 10 mg Injection, lanadelumab-flyo, 1 mg (code may be used for medicare when drug administered under direct supervision of a physician, not for use when drug is self-administered) Injection, lanoidase, 0.1 mg Leuprolide acetate (for depot suspension), 7.5 mg Injection, leuprolide acetate (for depot suspension), per 3.75 mg Injection, per 3.75 mg Injection, per 3.75 mg Injection, methylnaltresone, 0.1 mg Injection, methylnaltresone, 0.1 mg Injection, nusinersen, 0.1 mg Injection, oreilizumab, 1 mg Injection, oreilizumab, 1 mg Injection, oralbumab, 5 mg Injection, oralbumab, 5 mg Injection, onabotulinumtoxina, 1 unit Injection, natisvan, 0.1 mg Injection, patisvan, 0.1 mg Injection, pagapatanib sodium, 0.3 mg	11823 11745 10593 11931 119217 11950 10896 12182 12212 12212 12233 12326 12350 12350 12350	Prior Authorization is required.
Injection, inebilizumab. cdon, 1 mg Injection, infliximab, excludes biosimilar, 10 mg Injection, lanadelumab-flyo, 1 mg (code may be used for medicare when drug administered under direct supervision of a physician, not for use when drug is self-administered) Injection, laronidase, 0.1 mg Injection, laronidase, 0.1 mg Injection, leuprolide acetate (for depot suspension), per 3.75 mg Injection, leuprolide acetate (for depot suspension), per 3.75 mg Injection, nepolizumab, 1 mg Injection, methylinaltrexone, 0.1 mg Injection, natalizumab, 1 mg Injection, natalizumab, 1 mg Injection, onabotulinumtoxina, 1 unit Injection, onabotulinumtoxina, 1 unit Injection, onabotulinumtoxina, 1 unit Injection, pegapatanib sodium, 0.3 mg Injection, pegigrastim, excludes biosimilar, 0.5 mg	11823 11745 10593 11931 119217 11950 10896 12182 12212 12212 12323 12326 12357 10585 10585 10799 12503	Prior Authorization is required.
Injection, inebilizumab-cdon, 1 mg Injection, infloimab, excludes biosimilar, 10 mg Injection, infloimab, excludes biosimilar, 10 mg Injection, landelumab-flyo, 1 mg (code may be used for medicare when drug administered under direct supervision of a physician, not for use when drug is self- administered) Injection, landiase, 0.1 mg Leuprolide acetate (for depot suspension), 7.5 mg Injection, leuprolide acetate (for depot suspension), per 3.75 mg Injection, neprolitumab, 1 mg Injection, methylnaltresone, 0.1 mg Injection, nusibersone, 0.1 mg Injection, oraelizumab, 1 mg Injection, patisiran, 0.1 mg Injection, pegiparab sodium, 0.3 mg NOC drugs, other than inhalation drugs, administered through DME Injection, pegifigrastim, excludes biosimilar, 0.5 mg Injection, pegifigrastim, excludes biosimilar, 0.5 mg Injection, pegifigrastim, excludes biosimilar, 0.5 mg	11823 11745 10593 11931 119217 11950 10896 12182 12212 12213 12325 12350	Prior Authorization is required.
Injection, inebilizumab-cdon, 1 mg Injection, infliximab, excludes biosimilar, 10 mg Injection, lanadelumab-flyo, 1 mg (code may be used for medicare when drug administered under direct supervision of a physician, not for use when drug is self-administered) Injection, lanoidase, 0.1 mg Injection, lanoidase, 0.1 mg Injection, leuprolide acetate (for depot suspension), 7.5 mg Injection, leuprolide acetate (for depot suspension), per 3.75 mg Injection, leuprolide acetate (for depot suspension), per 3.75 mg Injection, neuprolide acetate (for depot suspension), per 3.75 mg Injection, methylinaltrexone, 0.1 mg Injection, mathylinaltrexone, 0.1 mg Injection, ornalizumab, 1 mg Injection, ornalizumab, 5 mg Injection, ornalizumab, 5 mg Injection, ornalizumab, 5 mg Injection, ornalizumab, 1 mg Injection, peggaptanib sodium, 0.3 mg Injection, peggaptanib sodium, 0.3 mg Injection, pegfigrastim, excludes biosimilar, 0.5 mg Injection, ranibzumab, 0.1 mg Injection, ranibzumab, 0.1 mg	11823 11745 10593 11931 119217 11950 10896 12182 12212 12323 12326 12350 12357 10585 10585 10799 12506 12507	Prior Authorization is required.
Injection, inebilizumab-cdon, 1 mg Injection, infliximab, excludes biosimilar, 10 mg Injection, infliximab, excludes biosimilar, 10 mg Injection, lanadelumab-flyo, 1 mg (code may be used for medicare when drug administered under direct supervision of a physician, not for use when drug is self- administered) injection, laronidase, 0.1 mg Injection, laronidase, 0.1 mg Injection, leuprolide acetate (for depot suspension), per 3.75 mg Injection, leuprolide acetate (for depot suspension), per 3.75 mg Injection, mepolizumab, 1 mg Injection, mapilizumab, 1 mg Injection, norelizumab, 1 mg Injection, ornalizumab, 2 mg Injection, ornalizumab, 5 mg Injection, ornalizumab, 5 mg Injection, pagpatrain sodium, 0.3 mg NOC drugs, other than inhalation drugs, administered through DME Injection, pegaptanib sodium, 0.3 mg Injection, pegaptanib sodium, 0.3 mg Injection, pegaptanib sodium, 0.1 mg Injection, pegaptanib sodium, 0.5 mg Injection, pegaptanib sodium, 0.5 mg Plasminogen, human-twith (Ryplazim) Injection, pegloticase, 1 mg Injection, ramibizumab, 0.1 mg	11823 11745 11931 11931 119217 11950 10896 12182 12182 12212 12323 12326 12326 12357 10585 102222 12503 17799 12506 12507 12998 12778	Prior Authorization is required.
Injection, inebilizumab-cdon, 1 mg Injection, infliximab, excludes biosimilar, 10 mg Injection, lanadelumab-flyo, 1 mg (code may be used for medicare when drug administered under direct supervision of a physician, not for use when drug is self-administered) Injection, lanoidase, 0.1 mg Injection, lanoidase, 0.1 mg Injection, leuprolide acetate (for depot suspension), 7.5 mg Injection, leuprolide acetate (for depot suspension), per 3.75 mg Injection, leuprolide acetate (for depot suspension), per 3.75 mg Injection, neuprolide acetate (for depot suspension), per 3.75 mg Injection, methylinaltrexone, 0.1 mg Injection, mathylinaltrexone, 0.1 mg Injection, ornalizumab, 1 mg Injection, ornalizumab, 5 mg Injection, ornalizumab, 5 mg Injection, ornalizumab, 5 mg Injection, ornalizumab, 1 mg Injection, peggaptanib sodium, 0.3 mg Injection, peggaptanib sodium, 0.3 mg Injection, pegfigrastim, excludes biosimilar, 0.5 mg Injection, ranibzumab, 0.1 mg Injection, ranibzumab, 0.1 mg	11823 11745 10593 11931 119217 11950 10896 12182 12212 12323 12326 12350 12357 10585 10585 10799 12506 12507	Prior Authorization is required.
Injection, inebilizumab-cdon, 1 mg Injection, infliximab, excludes biosimilar, 10 mg Injection, infliximab, excludes biosimilar, 10 mg Injection, lanadelumab-flyo, 1 mg (code may be used for medicare when drug administered under direct supervision of a physician, not for use when drug is self-administered) injection, laronidase, 0.1 mg Leuprolide acetate (for depot suspension), 7.5 mg Injection, leuprolide acetate (for depot suspension), per 3.75 mg Injection, hepsploide acetate (for depot suspension), per 3.75 mg Injection, mepolizumab, 1 mg Injection, malatzumab, 1 mg Injection, norelizumab, 1 mg Injection, norelizumab, 1 mg Injection, orelizumab, 1 mg Injection, orelizumab, 5 mg Injection, peapatanib sodium, 0.3 mg NOC drugs, other than inhalation drugs, administered through DME Injection, peapatanib sodium, 0.3 mg NOC drugs, other than inhalation drugs, administered through DME Injection, peaploticase, 1 mg Injection, reploticase, 1 mg Injection, resizumab, 1 mg Injection, resizumab, 1 mg Injection, rembotulinumtoxinb, 100 units Injection, rimabotulinumtoxinb, 100 units Injection, rimabotulinumtoxinb, 100 units	11823 11745 11931 11931 119217 11950 10896 12182 12182 12212 12323 12326 12325 12325 12327 12525 10222 12503 177799 12506 12507 12998 12778 12998 12778 12998 12778 12998 12778 12998	Prior Authorization is required.
Injection, inebilizumab. cdon, 1 mg Injection, infliximab, excludes biosimilar, 10 mg Injection, landaelumab flyo, 1 mg (code may be used for medicare when drug administered under direct supervision of a physician, not for use when drug is self-administered) Injection, landinistered) Injection, landinistered, 1 mg Injection, landinistered, 1 mg Injection, leuprolide acetate (for depot suspension), per 3.75 mg Injection, leuprolide acetate (for depot suspension), per 3.75 mg Injection, leuprolide acetate (for depot suspension), per 3.75 mg Injection, nepolizumab, 1 mg Injection, onepolizumab, 1 mg Injection, onabotulimuntosina, 1 unit Injection, pegapatranib sodium, 0.3 mg NOC drugs, other than inhalation drugs, administered through DME Injection, pegfigrastin, excludes biosimilar, 0.5 mg Injection, ranibizumab, 0.1 mg Injection, ranibizumab, 0.1 mg Injection, rituximab, 0.1 mg Injection, rituximab, 1.00 mg Injec	11823 11745 11931 11931 119217 11950 10896 12182 12212 12323 12326 12350 12350 12357 10585 10222 12503 17799 12506	Prior Authorization is required.
Injection, inebilizumab-cdon, 1 mg Injection, infliximab, excludes biosimilar, 10 mg Injection, infliximab, excludes biosimilar, 10 mg Injection, lanadelumab-flyo, 1 mg (code may be used for medicare when drug administered under direct supervision of a physician, not for use when drug is self-administered) injection, laronidase, 0.1 mg Leuprolide acetate (for depot suspension), 7.5 mg Injection, leuprolide acetate (for depot suspension), per 3.75 mg Injection, hepsploide acetate (for depot suspension), per 3.75 mg Injection, mepolizumab, 1 mg Injection, malatzumab, 1 mg Injection, norelizumab, 1 mg Injection, norelizumab, 1 mg Injection, orelizumab, 1 mg Injection, orelizumab, 5 mg Injection, peapatanib sodium, 0.3 mg NOC drugs, other than inhalation drugs, administered through DME Injection, peapatanib sodium, 0.3 mg NOC drugs, other than inhalation drugs, administered through DME Injection, peaploticase, 1 mg Injection, reploticase, 1 mg Injection, resizumab, 1 mg Injection, resizumab, 1 mg Injection, rembotulinumtoxinb, 100 units Injection, rimabotulinumtoxinb, 100 units Injection, rimabotulinumtoxinb, 100 units	11823 11745 10593 11931 11950 10896 12182 12212 12323 12326 12350 12357 10585 10522 12503 17799 12506 12507 12598 12778 111303 12786 10587	Prior Authorization is required.
Injection, inebilizumab - cdon, 1 mg Injection, infliximab, excludes biosimilar, 10 mg Injection, landelumab-filyo, 1 mg (code may be used for mediciare when drug administered under direct supervision of a physician, not for use when drug is self- administered) Injection, alranidase, 0.1 mg Injection, orabotulinumtoxina, 1 mg Injection, orabotulinumtoxina, 1 mit Injection, pegalizumab, 1 mg Injection, ravulizumab cwvz, 10 mg Injection, ravulizumab cwvz, 10 mg Injection, ravulizumab cwvz, 10 mg Injection, ravulizumab, 1 mg	11823 11745 10593 11931 11931 119517 11950 10896 12182 12323 12326 12337 10585 10522 12503 17999 12506 12507 12598 12778 131303 12786 10587 193312 12786 10587	Prior Authorization is required.
Injection, inebilizumab. excludes biosimilar, 10 mg Injection, inflisimab, excludes biosimilar, 10 mg Injection, lanadelumab-flyo, 1 mg (code may be used for medicare when drug administered under direct supervision of a physician, not for use when drug is self-administered) Injection, laroindase, 0.1 mg Injection, laroindase, 0.1 mg Injection, leuprolide acetate (for depot suspension), per 3.75 mg Injection, leuprolide acetate (for depot suspension), per 3.75 mg Injection, neuprilarian, 1 mg Injection, methylinaltrexone, 0.1 mg Injection, methylinaltrexone, 0.1 mg Injection, natalizumab, 1 mg Injection, onabotulinumtoxina, 1 unit Injection, onabotulinumtoxina, 1 unit Injection, opagaparanib sodium, 0.3 mg Injection, opagaparanib sodium, 0.3 mg Injection, pegfigrastim, excludes biosimilar, 0.5 mg Injection, ramibizumab, 0.1 mg Injection, ramibizumab, 10 mg Injection, rimabotulinumtoxinb, 100 units Injection, rimabotulinumtoxinb, 100 units Injection, rimabotulinumtoxinb, 100 units Injection, sebelipase alfa, 1 mg Uhclassified drugs	11823 11745 10593 11931 11931 119217 11950 10896 12182 12212 12323 12326 12357 10585 10585 10585 10585 12506 12507 12598 12778 11303 12786 11033 12786 10587 19512 12786 10587	Prior Authorization is required.
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Injection, inebilizumab. codon, 1 mg Injection, infliximab, excludes biosimilar, 10 mg Injection, infliximab, excludes biosimilar, 10 mg Injection, lanadelumab-flyo, 1 mg (code may be used for medicare when drug administered under direct supervision of a physician, not for use when drug is self- administered) Injection, laronidase, 0.1 mg Injection, laronidase, 0.1 mg Injection, leuprolide acetate (for depot suspension), 7.5 mg Injection, leuprolide acetate (for depot suspension), per 3.75 mg Injection, leuprolide acetate (for depot suspension), per 3.75 mg Injection, suspatercept-aamt, 0.25 mg Injection, methyniatrexone, 0.1 mg Injection, malaizumab, 1 mg Injection, onalizumab, 1 mg Injection, onalizumab, 1 mg Injection, onalizumab, 5 mg Injection, pegaptanib sodium, 0.3 mg NOC drugs, other than inhalation drugs, administered through DME Injection, pegaptanib sodium, 0.3 mg Injection, pegaptanib sodium, 0.1 mg Injection, pegaptanib sodium, 0.1 mg Injection, pegioticase, 1 mg Plasminogen, human-twmh (Ryplazim) Injection, ranibizumab, 0.1 mg Injection, ranibizumab, 0.1 mg Injection, ranibizumab, 1.0 mg Injection, ranibizumab, 1.0 mg Injection, ritusimab, 1.0 mg Injection, ritusimab, 1.0 mg Injection, taliglucerase alfa, 10 units Injection, taliglucerase alfa, 10 units Injection, testosterone cypionate, 1 mg Testosterone pellet, 75 mg Testosterone pellet, 75 mg	11823 11745 11931 11931 119217 11950 10896 12182 12182 12212 12323 12323 12337 12357 12556 12577 12998 12577 12998 12576 12597 12998 12778 111033 12786 12786 12998 12778 1303 12786 12799 12506 12507 12998 12778 1303 1303 1304 1304 13050 13060 13241 11071 150189	Prior Authorization is required.
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Injection, inchilizumab. excludes biosimilar, 10 mg Injection, infliximab, excludes biosimilar, 10 mg Injection, infliximab, excludes biosimilar, 10 mg Injection, lanadelumab-flyo, 1 mg (code may be used for medicare when drug administered under direct supervision of a physician, not for use when drug is self- administered) Injection, alenoidase, 0.1 mg Injection, leuprolide acetate (for depot suspension), 7.5 mg Injection, leuprolide acetate (for depot suspension), per 3.75 mg Injection, per politicumab, 1 mg Injection, mepolizumab, 1 mg Injection, mepolizumab, 1 mg Injection, melizumab, 1 mg Injection, onalizumab, 5 mg Injection, onalizumab, 5 mg Injection, onalizumab, 5 mg Injection, onalizumab, 1 mg Injection, pegapatanib sodium, 0.3 mg NOC drugo, other than inhaliation drugs, administered through DME Injection, pegfligrastim, excludes biosimilar, 0.5 mg Injection, pegfligrastim, excludes biosimilar, 0.5 mg Injection, ravilizumab, 1 mg Injection, ravilizumab covez, 10 mg Injection, ravilizumab, 1 mg Injection, ravilizumab Lorey, 10 mg Injection, ravilizumab Lorey, 10 mg Injection, resilizumab, 1 mg Injection, teprotumumab-trbw, 10 mg Injection, teprostinil, 1 mg Injection, teprostinil, 1 mg	11823 11745 10593 11931 11931 119517 11950 10896 12182 12323 12326 12327 12328 12327 12328 12327 12329 12357 105825 105222 12503 17799 12506 12597 12598 12778 13103 12786 10587 129312 12796 12840 13490 13600 13600 13601 13601 13611 11071 150189 13622 13785	Prior Authorization is required. Prior
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Injection, inebilizumab.cdon, 1 mg Injection, infliximab, excludes biosimilar, 10 mg Injection, infliximab, excludes biosimilar, 10 mg Injection, hanadelumab-flyo, 1 mg (code may be used for medicare when drug administered under direct supervision of a physician, not for use when drug is self-administered) Injection, laronidase, 0.1 mg Leuprolide acetate (for depot suspension), 7.5 mg Injection, leuprolide acetate (for depot suspension), per 3.75 mg Injection, leuprolide acetate (for depot suspension), per 3.75 mg Injection, leuprolide acetate (for depot suspension), per 3.75 mg Injection, mepolizumab, 1 mg Injection, mepolizumab, 1 mg Injection, mepolizumab, 1 mg Injection, orelizumab, 1 mg Injection, orelizumab, 1 mg Injection, orelizumab, 5 mg Injection, patistran, 0.1 mg Injection, per	11823 11745 10593 11931 11931 119517 11950 10896 12182 12323 12326 12327 12328 12327 12328 12327 12329 12357 105825 105222 12503 17799 12506 12597 12598 12778 13103 12786 10587 129312 12796 12840 13490 13600 13600 13601 13601 13611 11071 150189 13622 13785	Prior Authorization is required. Prior
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Ustekinumab, for intravenous injection, 1 mg	J3358	Prior Authorization is required.
Injection, vedolizumab, 1 mg Injection, velaglucerase alfa, 100 units	J3380	Prior Authorization is required. Prior Authorization is required.
Injection, veragucerase arra, 100 units Injection, verteporfin, 0.1 mg	J3385 J3396	Prior Authorization is required.
Injection, vestronidase alfa-vjbk, 1 mg	J3397	Prior Authorization is required.
Injection, von willebrand factor	J7179	Prior Authorization is required.
(recombinant), (vonvendi), 1 i.u. vwf:rco Injection, voretigene neparvovec-rzyl, 1	13398	Prior Authorization is required.
billion vector genomes	3330	Thornachorization stequines.
Injection, zoledronic acid, 1 mg	J3489	Prior Authorization is required.
Unclassified biologics	J3590	The following drugs and NDC codes require prior authorization: Aduhelm (70573-0099-01, 70573-0099-02)
Respite Care-Pediatrics	Codes	Prior Authorization Requirement
Unskilled respite care, not hospice, per	55150	Prior authorization is required. For additional information please refer to Respite Care-Pediatric, RP-1135.
15 minutes		
Unskilled respite care, not hospice, per diem	S5151	Prior authorization is required. For additional information please refer to Respite Care-Pediatric, RP-1135.
Respite care, in the home, per diem	59125	Prior authorization is required. For additional information please refer to Respite Care-Pediatric, RP-1135.
Respite care service, up to 15 minutes	T1005	Prior authorization is required. For additional information please refer to Respite Care-Pediatric, RP-1135.
Self-Directed Attendant Care-Pediatrics	Codes	Prior Authorization Requirement
Self-Directed Attendant Care Services,	55130	Prior authorization is required. For additional information please refer to Self-Directed Attendant Care-Non
per 15 minutes*	lo. I.	LTSS age 21 and Younger, RP-1133.
Diapers, Pads, and Supplies Perianal fecal collection pouch with adhesive,	Codes A4330	Prior Authorization Requirement Prior authorization is required if more than 8 units are billed per day.
each		
Enema bag with tubing, reusable Manual pump-operated enema system,	A4458 A4459	Prior authorization is required if more than 8 units are billed per day. Prior authorization is required if more than 8 units are billed per day.
includes balloon, catheter and all		. The decision is required if more than a units are blined per day.
accessories, reusable, any type Nondisposable underpads, all sizes	A4553	Prior authorization is required if more than 8 units are billed per day.
Disposable underpads, all sizes	A4554	Prior authorization is required if more than 8 units are billed per day.
Adult sized disposable incontinence product,	T4521	Prior authorization is required if more than 8 units are billed per day.
brief/diaper, small, each Adult sized disposable incontinence product,	T4522	Not a covered service for members under 4.
brief/diaper, medium, each	17,722	Prior authorization is required if more than 8 units are billed per day. Not a covered service for members under 4.
Adult sized disposable incontinence product,	T4523	Prior authorization is required if more than 8 units are billed per day.
brief/diaper, large, each	TATTO	Not a covered service for members under 4.
Adult sized disposable incontinence product, brief/diaper, extra large, each	T4524	Prior authorization is required if more than 8 units are billed per day. Not a covered service for members under 4.
Adult sized disposable incontinence product,	T4525	Prior authorization is required if more than 8 units are billed per day.
protective underwear/pull-on, small size, each		Not a covered service for members under 4.
Adult sized disposable incontinence product,	T4526	Prior authorization is required if more than 8 units are billed per day.
protective underwear/pull-on, medium size, each		Not a covered service for members under 4.
Adult sized disposable incontinence product,	T4527	Prior authorization is required if more than 8 units are billed per day.
protective underwear/pull-on, large size, each		Not a covered service for members under 4.
Adult sized disposable incontinence product,	T4528	Prior authorization is required if more than 8 units are billed per day.
protective underwear/pull-on, extra large size, each		Not a covered service for members under 4.
Pediatric sized disposable incontinence	T4529	Prior authorization is required if more than 8 units are billed per day.
product, brief/diaper, small/medium size, each		Not a covered service for members under 4.
Pediatric sized disposable incontinence product, brief/diaper, large size, each	T4530	Prior authorization is required if more than 8 units are billed per day.
Pediatric sized disposable incontinence	T4531	Not a covered service for members under 4. Prior authorization is required if more than 8 units are billed per day.
product, protective underwear/pull-on,	14331	Not a covered service for members under 4.
small/medium size, each Pediatric sized disposable incontinence	T4532	Prior authorization is required if more than 8 units are billed per day.
product, protective underwear/pull-on, large	17332	Not a covered service for members under 4.
size, each Youth sized disposable incontinence product,	T4533	Prior authorization is required if more than 8 units are billed per day.
brief/diaper, each		Not a covered service for members under 4.
Youth sized disposable incontinence product, protective underwear/pull-on, each	T4534	Prior authorization is required if more than 8 units are billed per day.
Disposable	T4535	Not a covered service for members under 4. Prior authorization is required if more than 8 units are billed per day.
liner/shield/guard/pad/undergarment, for	14333	i noi authorization is required il more than o difficiale biffed per day.
incontinence, each Incontinence product, disposable underpad,	T4541	Prior authorization is required if more than 8 units are billed per day.
large, each		
Incontinence product, disposable underpad, small size, each	T4542	Prior authorization is required if more than 8 units are billed per day.
Adult sized disposable incontinence product,	T4543	Prior authorization is required if more than 8 units are billed per day.
protective brief/diaper, above extra large, each		Not a covered service for members under 4.
Adult sized disposable incontinence product, protective underwear/pull-on, above extra	T4544	Prior authorization is required if more than 8 units are billed per day. Not a covered service for members under 4.
large, each		
Incontinence product, disposable, penile wrap, each	T4545	Prior authorization is required if more than 8 units are billed per day.
Not Otherwise Classified Codes	Codes	Prior Authorization Requirement
Unlisted anesthesia procedure(s) Unlisted procedure, excision pressure ulcer	01999 15999	Prior authorization is required.
Unlisted procedure: Skin, mucous	15999 17999	Prior authorization is required. Prior authorization is required.
membrane, and subcutaneous tissue		
Unlisted procedure: Breast	19499	Prior authorization is required.
Unlisted procedure, musculoskeletal system, general	20999	Prior authorization is required.
Unlisted maxillofacial prosthetic	21089	Prior authorization is required.
procedure Unlisted craniofacial and maxillofacial	21299	Prior authorization is required
procedure		Prior authorization is required.
Musculoskeletal procedure: Head	21499	Prior authorization is required.
Procedure: Neck or thorax	21899	Prior authorization is required.
Unlisted procedure: Spine Unlisted procedure, shoulder	22899 23929	Prior authorization is required. Prior authorization is required.
Unlisted procedure, shoulder Unlisted procedure, humerus or elbow	24999	Prior authorization is required. Prior authorization is required.
Unlisted procedure, forearm or wrist	25999	Prior authorization is required.
Unlisted procedure, hands or fingers	26989	Prior authorization is required.
Unlisted procedure, pelvis or hip joint Procedure: Knee	27299 27599	Prior authorization is required. Prior authorization is required.
Unlisted procedure, leg or ankle	27899	Prior authorization is required. Prior authorization is required.
Unlisted Casting/Strapping	29799	Prior authorization is required.
Arthroscopy general joint procedure	29999	Prior authorization is required.
Unlisted procedure: Nose Unlisted procedure, accessory sinuses	30999 31299	Prior authorization is required. Prior authorization is required
Unlisted procedure: Larynx	31599	Prior authorization is required. Prior authorization is required.
		a representation of the control of t

Unlisted procedure tooks house.		
Unlisted procedure, trachea, bronchi	31899	Prior authorization is required.
Unlisted procedure, lungs and pleura	32999	Prior authorization is required.
Cardiac Procedure	33999	Prior authorization is required.
Unlisted Procedure: Vascular injection	36299	Prior authorization is required.
Unlisted vascular endoscopy procedure	37501	Prior authorization is required.
Unlisted procedure: Vascular surgery	37799	Prior authorization is required.
Unlisted laparoscopy procedure, spleen	38129	Prior authorization is required.
Unlisted laparoscopy procedure, lymphatic	38589	Prior authorization is required.
system	38999	Marin Marin Control Control
Procedure: Hemic or lymphatic system Unlisted procedure, mediastinum	39499	Prior authorization is required. Prior authorization is required.
Unlisted procedure, mediastinum Unlisted procedure, diaphragm		
	39599	Prior authorization is required.
Procedure: Lips	40799	Prior authorization is required.
Unlisted procedure, vestibule of mouth Unlisted procedure, tongue, floor of mouth	40899	Prior authorization is required.
	41599	Prior authorization is required. Prior authorization is required.
Procedure: Dentoalveolar structure	41899 42299	Prior authorization is required.
Unlisted procedure: Palate, uvula Unlisted procedure, salivary glands or ducts	42699	·
		Prior authorization is required.
Unlisted procedure, pharynx, adenoids, or tonsils	42999	Prior authorization is required.
Unlisted laparoscopy procedure,	43289	Prior authorization is required.
esophagus		
Unlisted procedure, esophagus	43499	Prior authorization is required.
Laparoscopic procedure: Stomach	43659	Prior authorization is required.
General stomach surgery	43999	Prior authorization is required.
Laparoscopic procedure: Intestine (except	44238	Prior authorization is required.
rectum)		
Procedure: Intestine	44799	Prior authorization is required.
Unlisted procedure, Meckel's diverticulum and	44899	Prior authorization is required.
the mesentery Unlisted laparoscopy procedure, appendix	44979	Prior authorization is required
Unlisted laparoscopy procedure, appendix Unlisted procedure, colon	44979 45399	Prior authorization is required.
		Prior authorization is required.
Unlisted laparoscopy procedure, rectum	45499	Prior authorization is required.
Unlisted procedure, rectum	45999 46999	Prior authorization is required.
		Prior authorization is required. Prior authorization is required.
Laparoscopy procedure: Liver	47379	
Unlisted procedure, liver Unlisted laparoscopy procedure, biliary tract	47399	Prior authorization is required.
	47579	Prior authorization is required.
Unlisted procedure, biliary tract	47999	Prior authorization is required.
Unlisted procedure, pancreas	48999	Prior authorization is required.
Laparoscopy procedure: Abdomen,	49329	Prior authorization is required.
peritoneum, omentum	40000	Date - and -
Laparoscopic procedure: Hernioplasty,	49659	Prior authorization is required.
herniography, herniotomy Procedure: Abdomen, peritoneum, and	49999	Date Ab de
omentum	49999	Prior authorization is required.
Unlisted laparoscopy procedure, renal	50549	Prior authorization is required.
Unlisted laparoscopy procedure, reital	50949	Prior authorization is required.
Laparoscopy procedure: Bladder	51999	Prior authorization is required.
Unlisted procedure, urinary system	53899	Prior authorization is required.
Laporoscopic procedure: Testis	54699	Prior authorization is required.
Lanaroscopy procedure: Spermatic cord	55550	
Laparoscopy procedure: Spermatic cord	55559	Prior authorization is required.
Procedure: Male genital	55899	Prior authorization is required.
Procedure: Male genital Laparoscopy procedure: Uterus	55899 58578	Prior authorization is required. Prior authorization is required.
Procedure: Malegenital Laparoscopy procedure: Uterus Laparoscopy procedure: Uterus	55899 58578 58579	Prior authorization is required. Prior authorization is required. Prior authorization is required.
Procedure: Male genital Laparoscopy procedure: Uterus Laparoscopy procedure: Uterus Laparoscopy procedure: Ovary	55899 58578 58579 58679	Prior authorization is required. Prior authorization is required. Prior authorization is required. Prior authorization is required.
Procedure: Male genital Laparoscopy procedure: Uterus Laparoscopy procedure: Uterus Laparoscopy procedure: Ovary Unlisted procedure: Female genital	55899 58578 58579	Prior authorization is required. Prior authorization is required. Prior authorization is required.
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Procedure: Male genital Laparoscopy procedure: Uterus Laparoscopy procedure: Uterus Laparoscopy procedure: Everus Laparoscopy procedure: Everus Laparoscopy procedure: Evarus Unilisted procedure: Female genital system non-obstetrical Unilisted frozedure: Female genital system non-obstetrical unilisted fizaroscopy procedure, when performed Unilisted plagoroscopy procedure, maternity care and delivery Unilisted procedure, maternity care and delivery Unilisted procedure, maternity care and delivery Unilisted procedure, endocrine system Unilisted procedure, endocrine system Unilisted procedure, anterior segment of eye Unilisted procedure, extraocular muscle Unilisted procedure, posterior segment Unilisted procedure; extraocular muscle Unilisted procedure: Eyelid Procedure: Conjunctiva (eye) Procedure: Conjunctiva (eye) Procedure: Conjunctiva (eye) Unilisted procedure, unidale ear Unilisted procedure, temporal bone, middle flossa approach Unilisted procedure, temporal bone, middle flossa approach Unilisted procedure, some Unilisted procedure, enterporal bone, middle flossa approach Unilisted procedure, interventional) Unilisted procedure, interventional) Unilisted procedure, berapeutic radiology timeliment planning Unilisted procedure, herapeutic radiology timeliment management Unilisted endocrine procedure, diagnostic interventional	55899 58578 58579 58679 58679 58679 586899 59897 59897 59898 60659 60659 60699 64999 66999 67299 67399 67399 68399 69399 69949 69979 76496 76497 76498 76499 77799 77899	Prior authorization is required.
Procedure: Male genital Laparoscopy procedure: Uterus Laparoscopy procedure: Uterus Laparoscopy procedure: Everus Laparoscopy procedure: Everus Laparoscopy procedure: Evary Lunisted recodure: Female genital system non-obstetrical Unisted fetal invasive procedure, including ultrasound guidance, when performed Unisted fetal invasive procedure, maternity care and delivery Lunisted procedure, maternity care and delivery Lunisted procedure, maternity care and delivery Lunisted procedure, endocrine system Unisted procedure, posterior segment of eye Unisted procedure, posterior segment of eye Unisted procedure; System Unisted procedure: Eyelid Procedure: External ear Unisted procedure; India ear Lunisted procedure, impercat bone, middle fossa approach Unisted procedure, impercat bone, middle fossa approach Unisted procedure (eg. diagnostic, interventional) Unisted procedure (eg. diagnostic, interventional) Unisted durasour berocedure (eg. diagnostic, interventional) Unisted durasour berocedure (eg. diagnostic, interventional) Unisted procedure, beroperate procedure (eg. diagnostic, interventional) Unisted procedure, temperate radiology clinical treatment planning Unisted procedure, medical radiology clinical treatment planning Unisted procedure, medical adalon physics, dosimetry and treatment devices, and special services Unisted procedure, diagnostic Unisted procedure, diagnostic Unisted procedure, diagnostic Unisted procedure, diagnostic	55899 58578 58579 58679 58679 58679 58999 59897 59897 59898 60659 60659 60699 64999 66999 67299 67399 67399 68399 69399 69799 76496 76497 76496 76499 77799	Prior authorization is required.
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Procedure: Male genital Laparoscopy procedure: Uterus Laparoscopy procedure: Uterus Laparoscopy procedure: Everus Laparoscopy procedure: Everus Laparoscopy procedure: Evary Unilisted procedure: Female genital system non-obstetrical Unisted fracedure: Female genital system non-obstetrical Unisted fetal invasive procedure, including ultrasound guidance, when performed Unisted plagoroscopy procedure, maternity care and delivery Unisted procedure, maternity care and delivery Unisted procedure, maternity care and delivery Unisted procedure, endocrine system Unisted procedure, endocrine system Unisted procedure, endocrine system Unisted procedure, posterior segment of eye Unisted procedure, posterior segment Unisted procedure, posterior segment Unisted procedure: Conjunctiva (eye) Procedure: Everance are Unisted procedure: Unisted procedure Unisted procedure, endocrine Unisted procedure, unidale ear Unisted procedure, unid	55899 58578 58579 58679 58679 58679 586899 59897 59897 59898 60659 60659 60699 64999 66999 67299 67399 67399 68399 69399 69949 69979 76496 76497 76498 76499 77799 77899	Prior authorization is required.
Procedure: Male genital Laparoscopy procedure: Uterus Laparoscopy procedure: Uterus Laparoscopy procedure: Everus Laparoscopy procedure: Everus Laparoscopy procedure: Evary Laparoscopy procedure: Evary Lunisted recodure: Female genital system non-obstetrical Unisted fetal invasive procedure, including ultrasound guidance, when performed Unisted fetal invasive procedure, meternity care and delivery Lunisted procedure, maternity care and delivery Lunisted procedure, maternity care and delivery Lunisted procedure, endocrine system Unisted procedure, posterior segment of eye Unisted procedure, posterior segment of eye Unisted procedure; posterior segment of eye Unisted procedure, inmer ear Unisted procedure, endical procedure (eg. diagnostic, interventional) Unisted procedure, temperatior adiology clinical treatment planning Unisted procedure, medical procedure (eg. diagnostic, interventional) Unisted procedure, medical brachytherapy Unisted procedure, diagnostic ruclear medicine Unisted procedure, diagnostic nuclear medicine	55899 558578 58578 58578 58579 58679 58679 58999 59897 59898 59899 60659 60659 60699 66699 667299 67399 67399 67399 67399 67399 67399 67399 67399 67399 67399 76496 76497 76498 776499 77299 77399 77399 77399 77399 78299	Prior authorization is required.
Procedure: Male genital Laparoscopy procedure: Uterus Laparoscopy procedure: Uterus Laparoscopy procedure: Everus Laparoscopy procedure: Everus Laparoscopy procedure: Evary Laparoscopy procedure: Evary Laparoscopy procedure: Evary Lunisted fetal invasive procedure, including utersound guidance, when performed Unisted fetal invasive procedure, meternity care and delivery Lunisted procedure, maternity care and delivery Lunisted procedure, maternity care and delivery Lunisted procedure, endocrine system Unisted procedure, posterior segment of eye Unisted procedure, posterior segment of eye Unisted procedure; posterior segment eye Unisted procedure; eye Lunisted procedure; eye Lunisted procedure; eye Lunisted procedure, inner ear Unisted procedure, inner ear Uni	55899 55879 58579 58679 58679 58999 59897 59897 59898 59899 60659 60659 60699 66999 67299 67399 67399 67399 67399 69399 69399 69379 76496 76497 76498 776499 77799 77799 778099 78199	Prior authorization is required.
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Unlisted respiratory procedure, diagnostic nuclear medicine	78599	Prior authorization is required.
Unlisted nervous system procedure,	78699	Prior authorization is required.
diagnostic nuclear medicine		
Unlisted genitourinary procedure, diagnostic nuclear medicine	78799	Prior authorization is required.
Unlisted miscellaneous procedure, diagnostic	78999	Prior authorization is required.
nuclear medicine		
Radiophamaceutical Therapy	79999	Prior authorization is required.
Unlisted procedure: Urinalysis	81099	Prior authorization is required.
Unlisted molecular pathology procedure Unlisted multianalyte assay with	81479 81599	Prior authorization is required. Prior authorization is required.
algotithmic analysis procedure	91233	Prior authorization is required.
Pathology test	84591	Prior authorization is required.
Unlisted chemistry procedure	84999	Prior authorization is required.
Unlisted hematology procedure	85999	Prior authorization is required.
Unlisted immunology procedure	86849	Prior authorization is required.
Unlisted Transfusion Medicine procedure	86999	Prior authorization is required.
Immunoassay	87299	Prior authorization is required.
Infectious agent antigen detection by immunoassay with direct optical (ie. visual)	87899	Prior authorization is required.
observation; not otherwise specified		
Immunoassay	87450	Prior authorization is required.
Unlisted microbiology	87999	Prior authorization is required.
Cytopathology	88199	Prior authorization is required.
Unlisted cytogenetic study	88299	Prior authorization is required.
Surgical pathology procedure	88399	Prior authorization is required.
Pathology test Unlisted pathology	88749 89240	Prior authorization is required.
Reproductive laboratory procedure	89398	Prior authorization is required. Prior authorization is required.
Unlisted immune globulin	90399	Prior authorization is required.
Unlisted vaccine	90749	Prior authorization is required.
Unlisted psychiatric service or procedure	90899	Prior authorization is required.
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Diagnostic procedure	91299	Prior authorization is required.
Unlisted ophthalmological service or	92499	Prior authorization is required.
procedure Unlisted otorhinolaryngological service or	92700	Prior authorization is required.
procedure		
Unlisted cardiovascular service or	93799	Prior authorization is required.
procedure		
Noninvasive vascular procedure	93998	Prior authorization is required.
Pulmonary service Allergy immunology	94799 95199	Prior authorization is required. Prior authorization is required.
Unlisted neurological or neuromuscular	95999	Prior authorization is required.
diagnostic procedure		
Unlisted injectable/therapeutic	96379	Prior authorization is required.
Unlisted chemotherapeutic injectable	96549	Prior authorization is required.
procedure		
Unlisted special dermatological service or procedure	96999	Prior authorization is required.
Unlisted physical medicine	97039	Prior authorization is required.
Unlisted physical medicine	97139	Prior authorization is required.
Unlisted physical medicine	97799	Prior authorization is required.
	99199	Prior authorization is required.
Unlisted special service, procedure, or		
report		Prior authorization is required
report Evaluation and management service	99499 99600	Prior authorization is required. Prior authorization is required.
report	99499	Prior authorization is required. Prior authorization is required. Prior authorization is required.
report Evaluation and management service Unlisted home visit Mental health services, not otherwise specified	99499 99600 H0046	Prior authorization is required. Prior authorization is required.
report Evaluation and management service Unlisted home visit Mental health services, not otherwise specified Alcohol and/or other drug abuse services, not	99499 99600 H0046	Prior authorization is required.
report Evaluation and management service Unlisted home visit Mental health services, not otherwise specified Alcohol and/or other drug abuse services, not otherwise specified Unspecified oral dosage form, FDA-approved	99499 99600 H0046	Prior authorization is required. Prior authorization is required.
report Evaluation and management service Unilisted home visit Mental health services, not otherwise specified Alcohol and/or other drug abuse services, not otherwise specified Unspecified oral dosage form, FDA-approved prescription antiemetic, for use as a complete therapeutic substitute for an IV antiemetic at the time of chemotherapy treatment, not to exceed a 48-hour dosage regimen	99499 99600 H0046 H0047 Q0181	Prior authorization is required. Prior authorization is required. Prior authorization is required. Prior authorization is required.
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Miscellaneous dme supply or accessory, not otherwise specified	A9999	Prior authorization is required for billed charges greater than \$500.
Parenteral nutrition solution, not	B4185	Prior authorization is required for billed charges greater than \$500.
otherwise specified, 10 grams lipids		
Noc for enteral supplies Noc for parenteral supplies	B9998 B9999	Prior authorization is required for billed charges greater than \$500. Prior authorization is required for billed charges greater than \$500.
Implantable/insertable device, not	C1889	Prior authorization is required for billed charges greater than \$500.
otherwise classified		
Topical oxygen delivery system, not otherwise specified, includes all supplies	E0446	Prior authorization is required for billed charges greater than \$500.
and accessories		
Patient lift, bathroom or toilet, not	E0625	Prior authorization is required for billed charges greater than \$500.
otherwise classified Intermittent limb compression device	E0676	Prior authorization is required for billed charges greater than \$500.
(includes all accessories), not otherwise	20070	Find authorization is required to timed charges greater than \$500.
specified		
Electrical stimulation or electromagnetic wound treatment device, not otherwise	E0769	Prior authorization is required for billed charges greater than \$500.
classified		
Functional electrical stimulator,	E0770	Prior authorization is required for billed charges greater than \$500.
transcutaneous stimulation of nerve and/or muscle groups, any type, complete		
system, not otherwise specified		
Wheelchair, pediatric size, not otherwise	E1229	Prior authorization is required for billed charges greater than \$500.
specified Power wheelchair, pediatric size, not	E1239	Prior authorization is required for billed charges greater than \$500.
otherwise specified		
Durable medical equipment,	E1399	Prior authorization is required for billed charges greater than \$500.
miscellaneous Dialysis equipment, not otherwise	E1699	Prior authorization is required for billed charges greater than \$500.
specified		
Accessory for speech generating device, not otherwise classified	E2599	Prior authorization is required for billed charges greater than \$500.
Wheelchair component or accessory, not	K0108	Prior authorization is required for billed charges greater than \$500.
otherwise specified		
Power operated vehicle, not otherwise classified	K0812	Prior authorization is required for billed charges greater than \$500.
Power wheelchair, not otherwise	K0898	Prior authorization is required for billed charges greater than \$500.
classified		· • • • • • • • • • • • • • • • • • • •
Addition to spinal orthosis, not otherwise specified	L0999	Prior authorization is required for billed charges greater than \$500.
Spinal orthosis, not otherwise specified	L1499	Prior authorization is required for billed charges greater than \$500.
Lower extremity orthoses, not otherwise	L2999	Prior authorization is required for billed charges greater than \$500.
specified Orthopedic shoe, modification, addition	L3649	Prior authorization is required for billed charges greater than \$500.
or transfer, not otherwise specified	25045	The authorization stequired for bined charges greater than \$500.
Upper limb orthosis, not otherwise	L3999	Prior authorization is required for billed charges greater than \$500.
specified Lower extremity prosthesis, not	L5999	Prior authorization is required for billed charges greater than \$500.
otherwise specified	2333	The data nation stequited for since charges greater than \$500.
Upper extremity prosthesis, not	L7499	Prior authorization is required for billed charges greater than \$500.
otherwise specified Breast prosthesis, not otherwise specified	L8039	Prior authorization is required for billed charges greater than \$500.
		0-00-00-00-00-00-00-00-00-00-00-00-00-0
Unspecified maxillofacial prosthesis, by	L8048	Prior authorization is required for billed charges greater than \$500.
report, provided by a non-physician Unlisted procedure for miscellaneous	L8499	Prior authorization is required for billed charges greater than \$500.
prosthetic services		0-8
Miscellaneous external component,	L8608	Prior authorization is required for billed charges greater than \$500.
supply or accessory for use with the argus ii retinal prosthesis system		
Miscellaneous component, supply or	L8698	Prior authorization is required for billed charges greater than \$500.
accessory for use with total artificial heart system		
Prosthetic implant, not otherwise	L8699	Prior authorization is required for billed charges greater than \$500.
specified		
Miscellaneous supply or accessory for use with an external ventricular assist device	Q0507	Prior authorization is required for billed charges greater than \$500.
with an external ventricular assist device		
Miscellaneous supply or accessory for use	Q0508	Prior authorization is required for billed charges greater than \$500.
with an implanted ventricular assist		
device Miscellaneous supply or accessory for use	Q0509	Prior authorization is required for billed charges greater than \$500.
with any implanted ventricular assist		000 0 0000 Million A2001
device for which payment was not made under medicare part a		
Cast supplies, for unlisted types and	Q4050	Prior authorization is required for billed charges greater than \$500.
materials of casts		
Splint supplies, miscellaneous (includes	Q4051	Prior authorization is required for billed charges greater than \$500.
thermoplastics, strapping, fasteners, padding and other supplies)		
Skin substitute, not otherwise specified	Q4100	Prior authorization is required for billed charges greater than \$500.
Tracheostomy supply, not otherwise	\$8189	Prior authorization is required for billed charges greater than \$500.
classified Infection control supplies, not otherwise	58301	Prior authorization is required for billed charges greater than \$500.
specified		
Specialized supply, not otherwise	T2028	Prior authorization is required for billed charges greater than \$500.
specified, waiver Specialized medical equipment, not	T2029	Prior authorization is required for billed charges greater than \$500.
otherwise specified, waiver		
Supply, not otherwise specified	T5999	Prior authorization is required for billed charges greater than \$500.
Dispensing fee, unspecified hearing aid Hearing aid or assistive listening	V5090 V5267	Prior authorization is required for billed charges greater than \$500. Prior authorization is required for billed charges greater than \$500.
device/supplies/accessories, not		
otherwise specified	WEST A	Delegande de la constant de la const
Assistive listening device, not otherwise specified	V5274	Prior authorization is required for billed charges greater than \$500.
Assistive listening device, personal fm/dm	V5287	Prior authorization is required for billed charges greater than \$500.
receiver, not otherwise specified Hearing aid, not otherwise classified	VEZOS	Drive authorization is conviced for hilled charges greater the \$500
Hearing aid, not otherwise classified Hearing service, miscellaneous	V5298 V5299	Prior authorization is required for billed charges greater than \$500. Prior authorization is required for billed charges greater than \$500.
	L4210	Prior authorization is required for billed charges greater than \$500.
Repair orthotic device		

Prosthetic repair Site of Care	L7510 Codes	Prior authorization is required for billed charges greater than \$500. Prior Authorization Requirement
Policy Forthcoming	Codes	Prior Authorization Requirement
	Codes	Prior Authorization Requirement
KRAS (Kirsten rat sarcoma viral oncogene homolog) (eg. carcinoma) gene analysis; additional variant(s) (eg. codon 61, codon 146)	81276	Prior authorization is required. For additional information please reference Molecular Tumor Markers for Non-Small Lung Cancer, MP-DE-1028
MOLECULAR PATHOLOGY PROCEDURE LEVEL 5	81404	Prior authorization is required. For additional information please reference Molecular Tumor Markers for Non-Small Lung Cancer, MP-DE-1028
Morphometric analysis, tumor	88360	Prior authorization is required. For additional information please reference Molecular Tumor Markers for
immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, per specimen, each single antibody stain procedure; manual		Non-Small Lung Cancer, MP-DE-1028
Morphometric analysis, tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or serniquantitative, per specimen, each single antibody stain procedure; using computer-assisted technology	88361	Prior authorization is required. For additional information please reference Molecular Tumor Markers for Non-Small Lung Cancer, MP-DE-1028
Cochlear Implant	Codes	Prior Authorization Requirement
Cochlear device implantation, with or without mastoidectomy	69930	Prior authorization is required. Please refer to Cochlear Implants, MP-DE-1145 for medical necessity criteria.
cluttering)	92521	Prior authorization is required. Please refer to Cochlear Implants, MP-DE-1145 for medical necessity criteria.
Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria);	92522	Prior authorization is required. Please refer to Cochlear Implants, MP-DE-1145 for medical necessity criteria.
Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (eg, receptive and expressive language)	92523	Prior authorization is required. Please refer to Cochlear Implants, MP-DE-1145 for medical necessity criteria.
Behavioral and qualitative analysis of voice and resonance	92524	Prior authorization is required. Please refer to Cochlear Implants, MP-DE-1145 for medical necessity criteria.
Diagnostic analysis of cochlear implant, patient younger than 7 years of age; with	92601	Prior authorization is required. Please refer to Cochlear Implants, MP-DE-1145 for medical necessity criteria.
programming Diagnostic analysis of cochlear implant, patient younger than 7 years of age;	92602	Prior authorization is required. Please refer to Cochlear Implants, MP-DE-1145 for medical necessity criteria.
subsequent reprogramming Diagnostic analysis of cochlear implant, age 7 years or older, with programming	92603	Prior authorization is required. Please refer to Cochlear Implants, MP-DE-1145 for medical necessity criteria.
Diagnostic analysis of cochlear implant, age 7 years or older; subsequent reprogramming	92604	Prior authorization is required. Please refer to Cochlear Implants, MP-DE-1145 for medical necessity criteria.
Cochlear device, includes all internal and external components	L8614	Prior authorization is required for billed charges greater than \$500. Please refer to Cochlear Implants, MP-DE- 1145 for medical necessity criteria.
Headset/headpiece for use with cochlear implant device, replacement	L8615	Prior authorization is required for billed charges greater than \$500. Please refer to Cochlear Implants, MP-DE- 1145 for medical necessity criteria.
Microphone for use with cochlear implant device, replacement	L8616	Prior authorization is required for billed charges greater than \$500. Please refer to Cochlear Implants, MP-DE- 1145 for medical necessity criteria.
Transmitting coil for use with cochlear implant device, replacement	L8617	Prior authorization is required for billed charges greater than \$500. Please refer to Cochlear Implants, MP-DE- 1145 for medical necessity criteria.
Transmitter cable for use with cochlear implant device or auditory osseointegrated	L8618	Prior authorization is required for billed charges greater than \$500. Please refer to Cochlear Implants, MP-DE- 1145 for medical necessity criteria.
and controller, integrated system,	L8619	Prior authorization is required for billed charges greater than \$500. Please refer to Cochlear Implants, MP-DE- 1145 for medical necessity criteria.
replacement Zinc air battery for use with cochlear implant device and auditory osseointegrated sound	L8621	Prior authorization is required for billed charges greater than \$500. Please refer to Cochlear Implants, MP-DE-
processors, replacement, each Alkaline battery for use with cochlear implant	L8622	1145 for medical necessity criteria. Prior authorization is required for billed charges greater than \$500. Please refer to Cochlear Implants, MP-DE-
device, any size, replacement, each Lithium ion battery for use with cochlear	L8623	1145 for medical necessity criteria. Prior authorization is required for billed charges greater than \$500. Please refer to Cochlear Implants, MP-DE-
implant device speech processor, other than ear level, replacement, each		1145 for medical necessity criteria.
Lithium ion battery for use with cochlear implant or auditory osseointegrated device speech processor, ear level, replacement, each	L8624	Prior authorization is required for billed charges greater than \$500. Please refer to Cochlear Implants, MP-DE- 1145 for medical necessity criteria.
External recharging system for battery for use with cochlear implant or auditory osseointegrated device, replacement only, each	L8625	Prior authorization is required for billed charges greater than \$500. Please refer to Cochlear Implants, MP-DE- 1145 for medical necessity criteria.
Cochlear implant, external speech processor, component, replacement	L8627	Prior authorization is required for billed charges greater than \$500. Please refer to Cochlear Implants, MP-DE- 1145 for medical necessity criteria.
Cochlear implant, external controller component, replacement	L8628	Prior authorization is required for billed charges greater than \$500. Please refer to Cochlear Implants, MP-DE- 1145 for medical necessity criteria.
Transmitting coil and cable, integrated, for use with cochlear implant device, replacement	L8629	Prior authorization is required for billed charges greater than \$500. Please refer to Cochlear Implants, MP-DE- 1145 for medical necessity criteria.
Prosthetic implant, not otherwise specified	L8699	Prior authorization is required for billed charges greater than \$500. Please refer to Cochlear Implants, MP-DE- 1145 for medical necessity criteria.
Bariatric Surgery	Codes	Prior Authorization Requirement
Esophagogastroduodenoscopy, flexible, transoral; with dilation of esophagus with balloon (30 mm diameter or larger) (includes fluoroscopic guidance, when performed)	43233	Prior authorization is required. Please refer to Bariatric Surgery, MP-DE-1004 for additional requirements.
Esophagogastroduodenoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when	43235	Prior authorization is required. Please refer to Bariatric Surgery, MP-DE-1004 for additional requirements.
performed (separate procedure) Esophagogastroduodenoscopy, flexible, transoral; with directed submucosal	43236	Prior authorization is required. Please refer to Bariatric Surgery, MP-DE-1004 for additional requirements.
injection(s), any substance Esophagogastroduodenoscopy, flexible, transoral; with endoscopic ultrasound examination limited to the esophagus, stomach or duodenum, and adjacent	43237	Prior authorization is required. Please refer to Bariatric Surgery, MP-DE-1004 for additional requirements.
structures Esophagogastroduodenoscopy, flexible, transoral; with injection sclerosis of	43243	Prior authorization is required. Please refer to Bariatric Surgery, MP-DE-1004 for additional requirements.
esophageal/gastric varices Esophagogastroduodenoscopy, flexible, transoral; with band ligation of	43244	Prior authorization is required. Please refer to Bariatric Surgery, MP-DE-1004 for additional requirements.
esophageal/gastric varices Esophagogastroduodenoscopy, flexible,	43245	Prior authorization is required. Please refer to Bariatric Surgery, MP-DE-1004 for additional requirements.
transoral; with dilation of gastric/duodenal stricture(s) (eg. balloon, bougie)		

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Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-	43253	Prior authorization is required. Please refer to Bariatric Surgery, MP-DE-1004 for additional requirements.
guided transmural injection of diagnostic or		
therapeutic substance(s) (eg, anesthetic, neurolytic agent) or fiducial marker(s)		
(includes endoscopic ultrasound examination		
of the esophagus, stomach, and either the duodenum or a surgically altered stomach		
where the jejunum is examined distal to the		
anastomosis) Gastrectomy, partial, distal; with	43631	Prior authorization is required. Please refer to Bariatric Surgery, MP-DE-1004 for additional requirements.
gastroduodenostomy		
Gastrectomy, partial, distal; with gastrojejunostomy	43632	Prior authorization is required. Please refer to Bariatric Surgery, MP-DE-1004 for additional requirements.
Gastroctomy, partial, distal; with Roux-en-Y	43633	Prior authorization is required. Please refer to Bariatric Surgery, MP-DE-1004 for additional requirements.
reconstruction	42624	Delegant beginning in a service of Discourage to Delicate Course. MD DC 1004 for additional accordance
Gastrectomy, partial, distal; with formation of intestinal pouch	43634	Prior authorization is required. Please refer to Bariatric Surgery, MP-DE-1004 for additional requirements.
Laparoscopy, surgical, gastric restrictive procedure: with gastric bypass and Roux-en-	43644	Prior authorization is required. Please refer to Bariatric Surgery, MP-DE-1004 for additional requirements.
Y gastroenterostomy (roux limb 150 cm or		
less)	43645	Discontinuing in the control of Discontinuing Common AND DE 1004 for additional annihilation
Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and small	43043	Prior authorization is required. Please refer to Bariatric Surgery, MP-DE-1004 for additional requirements.
intestine reconstruction to limit absorption Laparoscopy, surgical, gastric restrictive	43770	Prior authorization is required. Please refer to Bariatric Surgery, MP-DE-1004 for additional requirements.
procedure; placement of adjustable gastric	43770	Filor authorization is required. Flease feler to Barrathic Surgery, Wir-DE-1004 for additional requirements.
restrictive device (eg, gastric band and subcutaneous port components)		
Laparoscopy, surgical, gastric restrictive	43771	Prior authorization is required. Please refer to Bariatric Surgery, MP-DE-1004 for additional requirements.
procedure; revision of adjustable gastric restrictive device component only		
Laparoscopy, surgical, gastric restrictive	43772	Prior authorization is required. Please refer to Bariatric Surgery, MP-DE-1004 for additional requirements.
procedure; removal of adjustable gastric restrictive device component only		
Laparoscopy, surgical, gastric restrictive	43773	Prior authorization is required. Please refer to Bariatric Surgery, MP-DE-1004 for additional requirements.
procedure; removal and replacement of adjustable gastric restrictive device		, , , , , , , , , , , , , , , , , , , ,
component only		
Laparoscopy, surgical, gastric restrictive	43774	Prior authorization is required. Please refer to Bariatric Surgery, MP-DE-1004 for additional requirements.
procedure; removal of adjustable gastric restrictive device and subcutaneous port		
components	40775	District the second of the sec
Laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy (ie,	43775	Prior authorization is required. Please refer to Bariatric Surgery, MP-DE-1004 for additional requirements.
sleeve gastrectomy)		
Gastric restrictive procedure, without gastric bypass, for morbid obesity; vertical-banded	43842	Prior authorization is required. Please refer to Bariatric Surgery, MP-DE-1004 for additional requirements.
gastroplasty	42042	District the second of the sec
Gastric restrictive procedure, without gastric bypass, for morbid obesity; other than	43843	Prior authorization is required. Please refer to Bariatric Surgery, MP-DE-1004 for additional requirements.
vertical-banded gastroplasty		
Gastric restrictive procedure with partial gastrectomy, pylorus-preserving	43845	Prior authorization is required. Please refer to Bariatric Surgery, MP-DE-1004 for additional requirements.
duodenoileostomy and ileoileostomy (50 to		
100 cm common channel) to limit absorption (biliopancreatic diversion with duodenal		
switch)		
Gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb	43846	Prior authorization is required. Please refer to Bariatric Surgery, MP-DE-1004 for additional requirements.
(150 cm or less) Roux-en-Y		
gastroenterostomy Gastric restrictive procedure, with gastric	43847	Prior authorization is required. Please refer to Bariatric Surgery, MP-DE-1004 for additional requirements.
bypass for morbid obesity; with small	15017	The determination of the control of
intestine reconstruction to limit absorption Revision, open, of gastric restrictive	43848	Prior authorization is required. Please refer to Bariatric Surgery, MP-DE-1004 for additional requirements.
procedure for morbid obesity, other than	13040	in or dution action is required. Trease relative buriative surgery, will be 2004 for duditional requirements.
adjustable gastric restrictive device (separate procedure)		
Revision of gastrojejunal anastomosis	43860	Prior authorization is required. Please refer to Bariatric Surgery, MP-DE-1004 for additional requirements.
(gastrojejunostomy) with reconstruction, with or without partial gastrectomy or intestine		
resection; without vagotomy		
Revision of gastrojejunal anastomosis (gastrojejunostomy) with reconstruction, with	43865	Prior authorization is required. Please refer to Bariatric Surgery, MP-DE-1004 for additional requirements.
or without partial gastrectomy or intestine		
resection; with vagotomy Gastric restrictive procedure, open; revision	43886	Prior authorization is required. Please refer to Bariatric Surgery, MP-DE-1004 for additional requirements.
of subcutaneous port component only		
Gastric restrictive procedure, open; removal of subcutaneous port component only	43887	Prior authorization is required. Please refer to Bariatric Surgery, MP-DE-1004 for additional requirements.
Gastric restrictive procedure, open; removal	43888	Prior authorization is required. Please refer to Bariatric Surgery, MP-DE-1004 for additional requirements.
and replacement of subcutaneous port component only		
Adjustment of gastric band diameter via	52083	Prior authorization is required. Please refer to Bariatric Surgery, MP-DE-1004 for additional requirements.
subcutaneous port by injection or aspiration of saline		
Colorectal Screenings	Codes	Prior Authorization Requirement
Computed tomographic (CT) colonography,	74263	Prior Authorization is required for members under the age of 45. Please refer to Colorectal Cancer Screening,
screening, including image postprocessing	74200	MP-DE-1007
Radiologic examination, colon, including scout abdominal radiograph(s) and delayed	74280	Prior Authorization is required for members under the age of 45. Please refer to Colorectal Cancer Screening, MP-DE-1007
image(s), when performed; double-contrast (eg, high density barium and air) study,		
including glucagon, when administered		
Oncology (colorectal) screening, quantitative real-time target and signal amplification of 10	81528	Prior Authorization is required for members under the age of 45. Please refer to Colorectal Cancer Screening,
DNA markers (KRAS mutations, promoter		MP-DE-1007
methylation of NDRG4 and BMP3) and fecal		
hemoglobin, utilizing stool, algorithm reported as a positive or negative result		
Plead appell by parallilate a state (193370	District Asherinting in the first and the control of the control o
Blood, occult, by peroxidase activity (eg, guaiac), qualitative; feces, consecutive	82270	Prior Authorization is required for members under the age of 45. Please refer to Colorectal Cancer Screening, MP-DE-1007
collected specimens with single		····
determination, for colorectal neoplasm screening (ie, patient was provided 3 cards or		
single triple card for consecutive collection)		
Blood, occult, by peroxidase activity (eg,	82272	Prior Authorization is required for members under the age of 45. Please refer to Colorectal Cancer Screening,
guaiac), qualitative, feces, 1-3 simultaneous	511,1	MP-DE-1007
determinations, performed for other than colorectal neoplasm screening		
Blood, occult, by fecal hemoglobin	82274	Prior Authorization is required for members under the age of 45. Please refer to Colorectal Cancer Screening,
determination by immunoassay, qualitative, feces, 1-3 simultaneous determinations		MP-DE-1007
Cytopathology, smears, any other source;	88160	Prior Authorization is required for members under the age of 45. Please refer to Colorectal Cancer Screening,
	i	MP-DE-1007
screening and interpretation	2000	
Colorectal cancer screening; flexible	G0104	Prior Authorization is required for members under the age of 45. Please refer to Colorectal Cancer Screening,
Colorectal cancer screening; flexible sigmoidoscopy		MP-DE-1007
Colorectal cancer screening; flexible		

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Colorectal cancer screening; alternative to G0104, screening sigmoidoscopy, barium enema	G0106	Prior Authorization is required for members under the age of 45. Please refer to Colorectal Cancer Screening, MP-DE-1007
Colorectal cancer screening; alternative to G0105, screening colonoscopy, barium	G0120	Prior Authorization is required for members under the age of 45. Please refer to Colorectal Cancer Screening, MP-DE-1007
enema olorectal cancer screening; colonoscopy on individual not meeting criteria for high risk	G0121	Prior Authorization is required for members under the age of 45. Please refer to Colorectal Cancer Screening,
olorectal cancer screening; barium enema	G0122	MP-DE-1007 Prior Authorization is required for members under the age of 45. Please refer to Colorectal Cancer Screening,
Colorectal cancer screening; fecal occult	G0328	MP-DE-1007 Prior Authorization is required for members under the age of 45. Please refer to Colorectal Cancer Screening,
blood test, immunoassay, one to three simultaneous determinations		MP-DE-1007
Pharmacogenomic Testing	Codes	Prior Authorization Requirement
DPYD (dihydropyrimidine dehydrogenase) (eg, 5-fluorouracil/5-FU and capecitabine drug	81232	Prior authorization is required. Please refer to Pharmacogenomic Testing, MP-DE-1002 for additional requirements.
metabolism), gene analysis, common variant(s) (eg, 2A, 4, 5, 6)		
TYMS (thymidylate synthetase) (eg, 5- fluorouracil/5-FU drug metabolism), gene analysis, common variant(s) (eg, tandem repeat variant)	81346	Prior authorization is required. Please refer to Pharmacogenomic Testing, MP-DE-1002 for additional requirements.
CYP3A4 (cytochrome P450 family 3 subfamily A member 4) (eg, drug metabolism), gene analysis, common variant(s) (eg, 2, 22)		Prior authorization is required. Please refer to Pharmacogenomic Testing, MP-DE-1002 for additional requirements.
CYP3A5 (cytochrome P450 family 3 subfamily A member 5) (eg, drug metabolism), gene analysis, common variants (eg, 2, 3, 4, 5, 6, 7)		Prior authorization is required. Please refer to Pharmacogenomic Testing, MP-DE-1002 for additional requirements.
IFNL3 (interferon, lambda 3) (eg, drug response), gene analysis, rs12979860 variant	81283	Prior authorization is required. Please refer to Pharmacogenomic Testing, MP-DE-1002 for additional requirements.
TPMT (thiopurine S-methyltransferase) (eg, drug metabolism), gene analysis, common	81335	Prior authorization is required. Please refer to Pharmacogenomic Testing, MP-DE-1002 for additional requirements.
variants (eg, 2, 3) G6PD (glucose-6-phosphate dehydrogenase)	81247	Prior authorization is required. Please refer to Pharmacogenomic Testing, MP-DE-1002 for additional
(eg, hemolytic anemia, jaundice), gene analysis; common variant(s) (eg, A, A-)		requirements.
SLCO1B1 (solute carrier organic anion transporter family, member 1B1) (eg, adverse drug reaction), gene analysis, common variant(s) (eg, 5)	81328	Prior authorization is required. Please refer to Pharmacogenomic Testing, MP-DE-1002 for additional requirements.
CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; common variants (eg, ACMG/ACOG guidelines)	81220	Prior authorization is required. Please refer to Pharmacogenomic Testing, MP-DE-1002 for additional requirements.
Thromboxane metabolite(s), including thromboxane if performed, urine	84431	Prior authorization is required. Please refer to Pharmacogenomic Testing, MP-DE-1002 for additional requirements.
Glucose-6-phosphate dehydrogenase (G6PD); quantitative	82955	Prior authorization is required. Please refer to Pharmacogenomic Testing, MP-DE-1002 for additional requirements.
Morphometric analysis, tumor immunohistochemistry (eg, Her-2/neu,	88360	Prior authorization is required. Please refer to Pharmacogenomic Testing, MP-DE-1002 for additional requirements.
estrogen receptor/progesterone receptor), quantitative or semiquantitative, per		
specimen, each single antibody stain procedure; manual		
Breast Reconstructive Surgery	Codes	Prior Authorization Requirement
Tattooing, intradermal introduction of	11920	Deliverable size is a second plane of the post post of the post of
	11720	Prior authorization is required. Please refer to Breast Reconstructive Surgery, MP-DE-1027 for additional
insoluble opaque pigments to correct color defects of skin, including micropigmentation;	11320	Prior authorization is required. Please refer to Breast Reconstructive Surgery, MP-DE-1027 for additional requirements.
insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.0 sq cm or less Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation;	11920	
insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.0 sq cm or less Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.1 to 20.0 sq cm Tattooing, intradermal introduction of		requirements. Prior authorization is required. Please refer to Breast Reconstructive Surgery, MP-DE-1027 for additional requirements. Prior authorization is required. Please refer to Breast Reconstructive Surgery, MP-DE-1027 for additional
Insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.0 s.g. cm or less Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.1 to 2.0 s.g. cm Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; each additional 2.0 s.g. cm, or part thereof (List separately) in addition to code for	11921	requirements. Prior authorization is required. Please refer to Breast Reconstructive Surgery, MP-DE-1027 for additional requirements.
Insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.0 sq. cm or less: 1 Tattooing, intrademal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.1 to 2.0 s agr. or Tattooing, intrademal introduction of Tattooing, intrademal introduction of correct color defects of skin, including micropigmentation; 6.0 sq. cm of skin, including micropigmentation; cach additional 2.0 sq. cm, or part thereof	11921	requirements. Prior authorization is required. Please refer to Breast Reconstructive Surgery, MP-DE-1027 for additional requirements. Prior authorization is required. Please refer to Breast Reconstructive Surgery, MP-DE-1027 for additional
Insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.0 s.g. cm or less Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.1 to 2.0 s.g. cm Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; each additional 2.0 s.g. cm, or part thereof (List separately in addition to code for primary procedure). Mastectomy, partial (eg, lumpectomy,	11921	requirements. Prior authorization is required. Please refer to Breast Reconstructive Surgery, MP-DE-1027 for additional requirements. Prior authorization is required. Please refer to Breast Reconstructive Surgery, MP-DE-1027 for additional requirements. Prior authorization is required. Please refer to Breast Reconstructive Surgery, MP-DE-1027 for additional requirements. Prior authorization is required. Please refer to Breast Reconstructive Surgery, MP-DE-1027 for additional requirements.
insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.0 s.g. cm or less Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.1 to 2.0 s.g. cm Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; each additional 2.0 s.g. cm, or part thereof (List separately in addition to code for primary procedure) Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy); Whetsetomy, quadrantectomy, segmentectomy; with axillary lymphadenectomy; with axillary lymphadenectomy; with axillary lymphadenectomy.	11921 11922 19301 19302	requirements. Prior authorization is required. Please refer to Breast Reconstructive Surgery, MP-DE-1027 for additional requirements. Prior authorization is required. Please refer to Breast Reconstructive Surgery, MP-DE-1027 for additional requirements. Prior authorization is required. Please refer to Breast Reconstructive Surgery, MP-DE-1027 for additional requirements. Prior authorization is required. Please refer to Breast Reconstructive Surgery, MP-DE-1027 for additional requirements.
insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.0 s.g. cm or less. Tattorion; intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.1 to 2.0 s.g. cm or less. Tattorion; intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; ach additional 2.00 s.g. cm, or part thereof (List separately in addition to code for primary procedural (e.g. lumpectomy, bylectomy, quadrantectomy, segmentectomy); Whastectomy, partial (e.g. lumpectomy, tylectomy, quadrantectomy, segmentectomy); with axillary lymphadenectomy.	11921 11922 19301 19302	Prior authorization is required. Please refer to Breast Reconstructive Surgery, MP-DE-1027 for additional requirements. Prior authorization is required. Please refer to Breast Reconstructive Surgery, MP-DE-1027 for additional requirements. Prior authorization is required. Please refer to Breast Reconstructive Surgery, MP-DE-1027 for additional requirements. Prior authorization is required. Please refer to Breast Reconstructive Surgery, MP-DE-1027 for additional requirements. Prior authorization is required. Please refer to Breast Reconstructive Surgery, MP-DE-1027 for additional requirements.
insoluble opaque pigments to correct color defects of skin, including micropigmentation; 8.0 s.g. cm or less Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 8.1 to 20.0 s.g. cm are microbide opaque pigments to correct color defects of skin, including micropigmentation; 8.1 to 20.0 s.g. cm, or and thread color defects of skin, including micropigmentation; each additional 20.0 s.g. cm, or part thereof (List separately in addition to code for primary procedure). Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy); will addition, quadrantectomy, segmentectomy); will availarly lymphadenectomy. Mastectomy, simple, complete Mastectomy, radical, including pectoral muscles, axillarly rymph nodes	11921 11922 19301 19302 19303	Prior authorization is required. Please refer to Breast Reconstructive Surgery, MP-DE-1027 for additional requirements. Prior authorization is required. Please refer to Breast Reconstructive Surgery, MP-DE-1027 for additional requirements. Prior authorization is required. Please refer to Breast Reconstructive Surgery, MP-DE-1027 for additional requirements. Prior authorization is required. Please refer to Breast Reconstructive Surgery, MP-DE-1027 for additional requirements. Prior authorization is required. Please refer to Breast Reconstructive Surgery, MP-DE-1027 for additional requirements. Prior authorization is required. Please refer to Breast Reconstructive Surgery, MP-DE-1027 for additional requirements.
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Breast reconstruction; with single-pedicled transverse rectus abdominis myocutaneous (TRAM) flap, requiring separate microvascular anastomosis (supercharging)	19368	Prior authorization is required. Please refer to Breast Reconstructive Surgery, MP-DE-1027 for additional requirements.
Breast reconstruction; with bipedicled transverse rectus abdominis myocutaneous (TRAM) flap	19369	Prior authorization is required. Please refer to Breast Reconstructive Surgery, MP-DE-1027 for additional requirements.
Preparation of moulage for custom breast implant	19396	Prior authorization is required. Please refer to Breast Reconstructive Surgery, MP-DE-1027 for additional requirements.
Unlisted procedure, breast	19499	Prior authorization is required. Please refer to Breast Reconstructive Surgery, MP-DE-1027 for additional requirements.
Adhesive skin support attachment for use with external breast prosthesis, each	A4280	Prior authorization is required for billed charges greater than \$500. Please refer to Breast Reconstructive Surgery, MP-DE-1027 for additional requirements.
Breast prosthesis, mastectomy bra, without integrated breast prosthesis form, any size,	L8000	Sorgery, wir-oc-1027 for additional requirements. Surgery, MP-DE-1027 for additional requirements.
any type Breast prosthesis, mastectomy bra, with	L8001	Prior authorization is required for billed charges greater than \$500. Please refer to Breast Reconstructive
integrated breast prosthesis form, unilateral, any size, any type	Longo	Surgery, MP-DE-1027 for additional requirements.
Breast prosthesis, mastectomy bra, with integrated breast prosthesis form, bilateral, any size, any type	L8002	Prior authorization is required for billed charges greater than \$500. Please refer to Breast Reconstructive Surgery, MP-DE-1027 for additional requirements.
Breast prosthesis, mastectomy sleeve	L8010	Prior authorization is required for billed charges greater than \$500. Please refer to Breast Reconstructive Surgery, MP-DE-1027 for additional requirements.
External breast prosthesis garment, with mastectomy form, post mastectomy	L8015	Prior authorization is required for billed charges greater than \$500. Please refer to Breast Reconstructive Surgery, MP-DE-1027 for additional requirements.
Breast prosthesis, mastectomy form	L8020	Prior authorization is required for billed charges greater than \$500. Please refer to Breast Reconstructive Surgery, MP-DE-1027 for additional requirements.
Breast prosthesis, silicone or equal, without integral adhesive	L8030	Prior authorization is required for billed charges greater than \$500. Please refer to Breast Reconstructive
Breast prosthesis, silicone or equal, with	L8031	Surgery, MP-DE-1027 for additional requirements. Prior authorization is required for billed charges greater than \$500. Please refer to Breast Reconstructive
integral adhesive Nipple prosthesis, prefabricated, reusable,	L8032	Surgery, MP-DE-1027 for additional requirements. Prior authorization is required for billed charges greater than \$500. Please refer to Breast Reconstructive
any type, each Custom breast prosthesis, post mastectomy,	L8035	Surgery, MP-DE-1027 for additional requirements. Prior authorization is required for billed charges greater than \$500. Please refer to Breast Reconstructive
molded to patient model Breast prosthesis, not otherwise specified	L8039	Surgery, MP-DE-1027 for additional requirements. Prior authorization is required for billed charges greater than \$500. Please refer to Breast Reconstructive
	Codes	Surgery, MP-DE-1027 for additional requirements.
BCR-BL1 Testing in Chronic Myeologenous Leukemia		Prior Authorization Requirement
ABL1 (ABL proto-oncogene 1, non-receptor tyrosine kinase) (eg, acquired imatinib tyrosine kinase inhibitor resistance), gene	81170	Prior authorization is required. Please refer to BCR-BL1 Testing in Chronic Myeologenous Leukemia, MP-DE- 1035 for additional requirements.
analysis, variants in the kinase domain BCR/ABL1 (t(9;22)) (eg, chronic myelogenous	81206	Prior authorization is required. Please refer to BCR-BL1 Testing in Chronic Myeologenous Leukemia, MP-DE-
leukemia) translocation analysis; major breakpoint, qualitative or quantitative	0.1200	1035 for additional requirements.
BCR/ABL1 (t(9;22)) (eg, chronic myelogenous leukemia) translocation analysis; minor breakpoint, qualitative or quantitative	81207	Prior authorization is required. Please refer to BCR-BL1 Testing in Chronic Myeologenous Leukemia, MP-DE- 1035 for additional requirements.
Deep Brain Stimulation	Codes	Prior Authorization Requirement
Twist drill or burr hole(s) for implantation of neurostimulator electrodes, cortical	61850	Prior authorization is required. Please refer to Deep Brain Stimulation, MP-DE-1009 for additional requirements.
Craniectomy or craniotomy for implantation of neurostimulator electrodes, cerebral, cortical	61860	Prior authorization is required. Please refer to Deep Brain Stimulation, MP-DE-1009 for additional requirements.
Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of	61863	Prior authorization is required. Please refer to Deep Brain Stimulation, MP-DE-1009 for additional requirements.
neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus,		requiences.
subthalamic nucleus, periventricular, periaqueductal gray), without use of intraoperative microelectrode recording: first		
array Twist drill, burr hole, craniotomy, or	61864	Prior authorization is required. Please refer to Deep Brain Stimulation, MP-DE-1009 for additional
craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical	01004	requirements.
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)		
Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical	61867	Prior authorization is required. Please refer to Deep Brain Stimulation, MP-DE-1009 for additional requirements.
site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular.		
periaqueductal gray), with use of intraoperative microelectrode recording; first		
array Twist drill, burr hole, craniotomy, or	61868	Prior authorization is required. Please refer to Deep Brain Stimulation, MP-DE-1009 for additional
craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus,		requirements.
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) Revision or removal of intracranial	61880	Prior authorization is required. Please refer to Deep Brain Stimulation, MP-DE-1009 for additional
neurostimulator electrodes Insertion or replacement of cranial	61885	requirements. Prior authorization is required. Please refer to Deep Brain Stimulation, MP-DE-1009 for additional
neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array		requirements.
Insertion or replacement of cranial neurostimulator pulse generator or receiver,	61886	Prior authorization is required. Please refer to Deep Brain Stimulation, MP-DE-1009 for additional requirements.
direct or inductive coupling; with connection to 2 or more electrode arrays		
Revision or removal of cranial neurostimulator pulse generator or receiver	61888	Prior authorization is required. Please refer to Deep Brain Stimulation, MP-DE-1009 for additional requirements.
Electrocorticogram from an implanted brain neurostimulator pulse generator/transmitter, including recording, with interpretation and	95836	Prior authorization is required. Please refer to Deep Brain Stimulation, MP-DE-1009 for additional requirements.
written report, up to 30 days Functional cortical and subcortical mapping	95961	Prior authorization is required. Please refer to Deep Brain Stimulation, MP-DE-1009 for additional
by stimulation and/or recording of electrodes on brain surface, or of depth electrodes, to		requirements.
provoke seizures or identify vital brain		
provoke seizures or identify vital brain structures; initial hour of attendance by a physician or other qualified health care		

E-standard and advantage and a second	locaca.	n in the interest of the property of the prope
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)	95962	Prior authorization is required. Please refer to Deep Brain Stimulation, MP-DE-1009 for additional requirements.
Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg. contact group(s), interleaving, amplitude, pulse width, frequency [1:2], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain, cranial nerve, spinal cord, peripheral nerve, or sacral nerve, without programming	95970	Prior authorization is required. Please refer to Deep Brain Stimulation, MP-DE-1009 for additional requirements.
Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg. contact group(s), interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with simple spinal cord or peripheral nerve (eg. sacrat nerve) neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional	95971	Prior authorization is required. Please refer to Deep Brain Stimulation, MP-DE-1009 for additional requirements.
Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg. contact group(s), interleaving, amplitude, pulse width, frequency [142], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with complex spinal cord or peripheral nerve (eg. sacral nerve) neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional	95972	Prior authorization is required. Please refer to Deep Brain Stimulation, MP-DE-1009 for additional requirements.
Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg. contact group(s), interleaving, amplitude, pulse width, frequency [142], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed toop parameters, and passive parameters) by physician or other qualified health care professional; with simple cranial nerve neurostimulator pulse generator/transmitter programming by physician or other qualified health care programming by physician or other qualified health care programming by physician or other qualified health care professional.	95976	Prior authorization is required. Please refer to Deep Brain Stimulation, MP-DE-1009 for additional requirements.
Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg., contact group(s), interleaving, amplitude, pulse width, frequency [vtz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional, with complex cranial nerverostimulator pulse generator/transmitter programming by physician or other qualified health care professional.	95977	Prior authorization is required. Please refer to Deep Brain Stimulation, MP-DE-1009 for additional requirements.
Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg. contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain neurostimulator pulse generator/transmitter programming, first 15 minutes face-lo-face time with physician or other qualified health care professional	95983	Prior authorization is required. Please refer to Deep Brain Stimulation, MP-DE-1009 for additional requirements.
Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg. contact group(s), interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed toop parameters, and passive parameters) by physician or other qualified health care professional; with brain neurostimulator pulse generator/transmitter programming, each additional 15 minutes face-to-face time with physician or other qualified health care professional; (List separately in addition to code for primary procedure)	95984	Prior authorization is required. Please refer to Deep Brain Stimulation, MP-DE-1009 for additional requirements.
Patient programmer (external) for use with implantable programmable neurostimulator pulse generator, replacement only	L8681	Prior authorization is required for billed charges greater than \$500. Please refer to Deep Brain Stimulation, MP-DE-1009 for additional requirements.
Radiofrequency transmitter (external) for use with implantable neurostimulator radiofrequency receiver	L8683	Prior authorization is required for billed charges greater than \$500. Please refer to Deep Brain Stimulation, MP-DE-1009 for additional requirements.
Radiofrequency transmitter (external) for use with implantable sacral root neurostimulator receiver for bowel and bladder management, replacement	L8684	Prior authorization is required for billed charges greater than \$500. Please refer to Deep Brain Stimulation, MP-DE-1009 for additional requirements.
Teplacement External recharging system for battery (internal) for use with implantable neurostimulator, replacement only	L8689	Prior authorization is required for billed charges greater than \$500. Please refer to Deep Brain Stimulation, MP-DE-1009 for additional requirements.

External rocharging system for battery (external) for use with implantable neurostimulator, replacement only Whole Exome/Whole Genome Sequencing United molecular pathology procedure Prior authorization is required for billed charges greater than \$500. Please refer to MP-DE-1009 for additional requirements. Prior authorization Requirements Prior authorization Requirements 1479 Prior authorization Requirements 1479 Prior authorization Requirements 1479 Prior authorization is required. Please refer to Whole Exome/Whole Genome Sequencing additional requirements. Prior authorization is required. Please refer to Whole Exome/Whole Genome Sequencing additional requirements.	
Whole Exome/Whole Genome Sequencing Unlisted molecular pathology procedure S1479 Prior authorization is required. Please refer to Whole Exome/Whole Genome Sequaditional requirements. Pain management, mRNA, gene expression profiling by RNA sequencing of 36 genes, additional requirements.	uencing, MP-DE-1012 for
Unlisted molecular pathology procedure 81479 Prior authorization is required. Please refer to Whole Exome/Whole Genome Seqiadditional requirements. Pain management, mRNA, gene expression profiling by RNA sequencing of 36 genes, additional requirements.	uencing, MP-DE-1012 for
Pain management, mRNA, gene expression 0290U Prior authorization is required. Please refer to Whole Exome/Whole Genome Sequently RNA sequencing of 36 genes, additional requirements.	
profiling by RNA sequencing of 36 genes, additional requirements.	uencing, MP-DE-1012 for
risk score	
Kidney Transplant Codes Prior Authorization Requirement Donor nephrectomy (Including cold 50320 Prior authorization is required. Please refer to Kidney Transplant, MP-DE-1017 for	or additional requirements
preservation); open, from living donor	
Recipient nephrectomy (separate procedure) 50340 Prior authorization is required. Please refer to Kidney Transplant, MP-DE-1017 for Renal allotransplantation in Figure 1 Source 1 Source 1 Source 2 Prior authorization is required. Please refer to Kidney Transplant, MP-DE-1017 for Renal allotransplantation in Figure 2 Source 2 Prior authorization is required. Please refer to Kidney Transplant, MP-DE-1017 for Prior authorization is required. Please refer to Kidney Transplant, MP-DE-1017 for Prior authorization is required.	·
graft; without recipient nephrectomy	·
Renal allotransplantation, implantation of graft; with recipient nephrectomy 50365 Prior authorization is required. Please refer to Kidney Transplant, MP-DE-1017 for graft; with recipient nephrectomy	r additional requirements.
Removal of transplanted renal allograft 50370 Prior authorization is required. Please refer to Kidney Transplant, MP-DE-1017 for	·
Renal autotransplantation, reimplantation of kidney Transplant, MP-DE-1017 for kidney Transplant, MP-DE-1017 for authorization is required. Please refer to Kidney Transplant, MP-DE-1017 for Laparoscopy, surgical; donor ne	·
(including cold preservation), from living donor	raduttonarrequirements.
Abdominoplasty and Panniculectomy Excision, excessive skin and subcutaneous 15830 Prior Authorization Requirement Prior authorization is required. Please refer to Abdominoplasty and Panniculecto Prior authorization is required.	omy, MP-DE-1003 for
tissue (includes lipectomy); abdomen, infraumbilical panniculectomy additional requirements.	
Excision, excessive skin and subcutaneous IS847 Prior authorization is required. Please refer to Abdominoplasty and Panniculecto additional requirements.	my, MP-DE-1003 for
transposition and fascial plication) (List separately in addition to code for primary procedure)	
Aqueous Shunts and Stents for Glaucoma Codes Prior Authorization Requirement	MD DE 4024 (
canal; without retention of device or stent additional requirements.	ucoma, MP-DE-1024 for
Insertion of anterior segment aqueous 66183 Prior authorization is required. Please refer to Aqueous Shunts and Stents for Glau drainage device, without extraocular additional requirements.	ucoma, MP-DE-1024 for
reservoir, external approach Transluminal dilation of aqueous outflow 66175 Prior authorization is required. Please refer to Aqueous Shunts and Stents for Glau	ucoma, MP-DE-1024 for
Implantable Hormone Replacement Codes Prior Authorization Requirement	
Pellets Pellets Subcutaneous hormone pellet implantation 11980 Prior authorization is required. Please refer to Implantable Hormone Replacemen	nt Pellets. MP-DE-1033 for
(implantation of estradiol and/or testosterone pollets beneath the skin) Cognitive Rehabilitation Codes Prior Authorization Requirement	
Therapeutic interventions that focus on 97129 Prior authorization is required. Please refer to Cognitive Rehabilitation, MP-DE-11	.044 for additional
cognitive function (eg., attention, memory, reasoning, executive function, problem	
solving, and/or pragmatic functioning) and compensatory strategies to manage the	
performance of an activity (eg, managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one)	
patient contact; initial 15 minutes Therapeutic interventions that focus on 97130 Prior authorization is required. Please refer to Cognitive Rehabilitation, MP-DE-1	044 for additional
cognitive function (eg. attention, memory, reasoning, executive function, problem	
solving, and/or pragmatic functioning) and compensatory strategies to manage the	
performance of an activity (eg. managing time or schedules, initiating, organizing, and	
sequencing tasks), direct (one-on-one) patient contact; each additional 15 minutes	
(List separately in addition to code for primary procedure)	
Psychiatric Care Defined Codes Prior Authorization Requirement Electroconvulsive therapy (includes 90870 Prior authorization is required. Please refer to Psychiatric Care Defined, MP-DE-16	046 for additional
necessary monitoring) requirements.	
Developmental test administration (including assessment of fine and/or gross motor, Please refer to Psychiatric Care Defined, MP-DE-10 requirements.	046 for additional
language, cognitive level, social, memory and/or executive functions by standardized	
developmental instruments when performed), by physician or other qualified health care	
professional, with interpretation and report; first hour	
Standardized cognitive performance testing leg, Ross Information Processing Prior authorization is required. Please refer to Psychiatric Care Defined, MP-DE-10 requirements.	046 for additional
Assessment) per hour of a qualified health care professional's time, both face-to-face	
time administering tests to the patient and time interpreting these test results and	
preparing the report Prior authorization is required. Please refer to Psychiatric Care Defined, MP-DE-10 Prior authorization is required. Please refer to Psychiatric Care Defined, MP-DE-10	046 for additional
physician or other qualified health care professional, including integration of patient requirements.	
data, interpretation of standardized test results and clinical data, clinical decision	
making, treatment planning and report, and interactive feedback to the patient, family	
member(s) or caregiver(s), when performed; first hour	
Psychological testing evaluation services by 96131 Prior authorization is required. Please refer to Psychiatric Care Defined, MP-DE-10 physician or other qualified health care requirements.	046 for additional
professional, including integration of patient data, interpretation of standardized test	
results and clinical data, clinical decision making, treatment planning and report, and	
interactive feedback to the patient, family member(s) or caregiver(s), when performed;	
Intercetts or Categore (s), when personned, each additional hour (List separately in addition to code for primary procedure)	
	046 for additional
Neuropsychological testing evaluation 96132 Prior authorization is required. Please refer to Psychiatric Care Defined, MP-DE-10	
Neuropsychological testing avaluation services by physician or other qualified health care professional, including integration	
Neuropsychological testing avaluation saving a property of the	
Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized	

Neuropsychological testing evaluation	96133	Prior authorization is required. Please refer to Psychiatric Care Defined, MP-DE-1046 for additional
services by physician or other qualified health care professional, including integration		requirements.
of patient data, interpretation of standardized		
test results and clinical data, clinical decision making, treatment planning and report, and		
interactive feedback to the patient, family		
member(s) or caregiver(s), when performed; each additional hour (List separately in		
addition to code for primary procedure)	1	
Psychological or neuropsychological test	96136	Prior authorization is required. Please refer to Psychiatric Care Defined, MP-DE-1046 for additional
administration and scoring by physician or	50150	requirements.
other qualified health care professional, two or more tests, any method; first 30 minutes		
Psychological or neuropsychological test	96137	Prior authorization is required. Please refer to Psychiatric Care Defined, MP-DE-1046 for additional
administration and scoring by physician or other qualified health care professional, two		requirements.
or more tests, any method; each additional		
30 minutes (List separately in addition to code for primary procedure)		
Psychological or neuropsychological test	96146	Prior authorization is required. Please refer to Psychiatric Care Defined, MP-DE-1046 for additional
administration, with single automated, standardized instrument via electronic		requirements.
platform, with automated result only		
Behavior identification assessment, administered by a physician or other qualified	97151	Prior authorization is required. Please refer to Psychiatric Care Defined, MP-DE-1046 for additional requirements.
health care professional, each 15 minutes of		requirements.
the physician's or other qualified health care professional's time face-to-face with patient		
and/or guardian(s)/caregiver(s) administering		
assessments and discussing findings and recommendations, and non-face-to-face		
analyzing past data, scoring/interpreting the		
assessment, and preparing the report/treatment plan		
Small Bowel, Liver, and Multivisceral	Codes	Prior Authorization Requirement
Transplantation Donor enterectomy (including cold	44133	Prior authorization is required. Please refer to Small Bowel, Liver, and Multivisceral Transplantation, MP-DE-
preservation), open; partial, from living donor		1051 for additional requirements.
Intestinal allotransplantation; from cadaver	44135	Prior authorization is required. Please refer to Small Bowel, Liver, and Multivisceral Transplantation, MP-DE-
donor Intestinal allotransplantation; from living	44136	1051 for additional requirements. Prior authorization is required. Please refer to Small Bowel, Liver, and Multivisceral Transplantation, MP-DE-
donor		1051 for additional requirements.
Liver allotransplantation, orthotopic, partial or whole, from cadaver or living donor, any age	47135	Prior authorization is required. Please refer to Small Bowel, Liver, and Multivisceral Transplantation, MP-DE- 1051 for additional requirements.
Unlisted procedure, liver	47399	Prior authorization is required. Please refer to Small Bowel, Liver, and Multivisceral Transplantation, MP-DE-
		1051 for additional requirements.
Unlisted procedure, small intestine	44799	Prior authorization is required. Please refer to Small Bowel, Liver, and Multivisceral Transplantation, MP-DE- 1051 for additional requirements.
Radiofrequency Ablation and	Codes	Prior Authorization Requirement
Cryosurgery of Primary or Metastatic Liver Tumors		
Laparoscopy, surgical, ablation of 1 or more liver tumor(s); radiofrequency	47370	Prior authorization is required. Please refer to Radiofrequency Ablation and Cryosurgery of Primary or Metastatic Liver Tumors, MP-DE-1052 for additional requirements.
Ablation, open, of 1 or more liver tumor(s);	47380	Prior authorization is required. Please refer to Radiofrequency Ablation and Cryosurgery of Primary or
radiofrequency Ablation, 1 or more liver tumor(s),	47382	Metastatic Liver Tumors, MP-DE-1052 for additional requirements. Prior authorization is required. Please refer to Radiofrequency Ablation and Cryosurgery of Primary or
percutaneous, radiofrequency		Metastatic Liver Tumors, MP-DE-1052 for additional requirements.
Laparoscopy, surgical, ablation of 1 or more liver tumor(s); cryosurgical	47371	Prior authorization is required. Please refer to Radiofrequency Ablation and Cryosurgery of Primary or Metastatic Liver Tumors, MP-DE-1052 for additional requirements.
Ablation, open, of 1 or more liver tumor(s); cryosurgical	47381	Prior authorization is required. Please refer to Radiofrequency Ablation and Cryosurgery of Primary or Metastatic Liver Tumors, MP-DE-1052 for additional requirements.
Ablation, 1 or more liver tumor(s),	47383	Prior authorization is required. Please refer to Radiofrequency Ablation and Cryosurgery of Primary or
percutaneous, cryoablation Endovascular Procedures for Intracranial	Codes	Metastatic Liver Tumors, MP-DE-1052 for additional requirements. Prior Authorization Requirement
and Extracranial Cerebral Vascular Disease		
Transcatheter placement of intravascular	37215	Prior authorization is required. Please refer to Endovascular Procedures for Intracranial and Extracranial
stent(s), cervical carotid artery, open or percutaneous, including angioplasty, when		Cerebral Vascular Disease, MP-DE-1056 for additional requirements.
performed, and radiological supervision and interpretation; with distal embolic protection		
Transcatheter placement of intravascular	37216	Prior authorization is required. Please refer to Endovascular Procedures for Intracranial and Extracranial
stent(s), cervical carotid artery, open or	1	
	I	Cerebral Vascular Disease, MP-DE-1056 for additional requirements.
percutaneous, including angioplasty, when performed, and radiological supervision and		
performed, and radiological supervision and interpretation; without distal embolic		
performed, and radiological supervision and interpretation; without distal embolic protection Transcatheter placement of intravascular	37218	Cerebral Vascular Disease, MP-DE-1056 for additional requirements. Prior authorization is required. Please refer to Endovascular Procedures for Intracranial and Extracranial
performed, and radiological supervision and interpretation; without distal embolic protection Transcatheter placement of intravascular stent(s), intrathoracic common carotid artery	37218	Cerebral Vascular Disease, MP-DE-1056 for additional requirements.
performed, and radiological supervision and interpretation; without distal embolic protection. Transcatheter placement of intravascular stent(s), intrathoracic common carotid artery or innominate artery, open or percutaneous antegrade approach, including angioplasty,	37218	Cerebral Vascular Disease, MP-DE-1056 for additional requirements. Prior authorization is required. Please refer to Endovascular Procedures for Intracranial and Extracranial
performed, and radiological supervision and interpretation; without distal embolic protection 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	37218	Cerebral Vascular Disease, MP-DE-1056 for additional requirements. Prior authorization is required. Please refer to Endovascular Procedures for Intracranial and Extracranial
performed, and radiological supervision and interpretation; without distal embloic protection. Transcatheter placement of intravascular sten(s), Intrathoracic common carotid artery or innorninate artery, open or percutaneous antegrade approach, including angioplasty, when performed, and radiological supervision and interpretation. Selective catheter placement, each	37218 36228	Cerebral Vascular Disease, MP-DE-1056 for additional requirements. Prior authorization is required. Please refer to Endovascular Procedures for Intracranial and Extracranial Cerebral Vascular Disease, MP-DE-1056 for additional requirements. Prior authorization is required. Please refer to Endovascular Procedures for Intracranial and Extracranial
performed, and radiological supervision and interpretation, without distal embolic protection. Transcatheter placement of intravascular stent(s), intrathoracic common carotid artery or innominate artery, open or percutaneous antergrade approach, including antipolasty, when performed, and radiological supervision and interpretation. Selective catheter placement, each intrazernatial branch of the internal carotid or		Cerebral Vascular Disease, MP-DE-1056 for additional requirements. Prior authorization is required. Please refer to Endovascular Procedures for Intracranial and Extracranial Cerebral Vascular Disease, MP-DE-1056 for additional requirements.
performed, and radiological supervision and interpretation, without distal embloid protection protection. Transcatheter placement of intravascular stent(s), intrathoracic common carotid artery or innominate artery, open or percutaneous antergarde approach, including angioplasty, when performed, and radiological supervision and interpretation. Selective catheter placement, each intracranial branch of the internal carotid or vertebral arteries, unilateral, with angiography of the selected vessel circulation and all		Cerebral Vascular Disease, MP-DE-1056 for additional requirements. Prior authorization is required. Please refer to Endovascular Procedures for Intracranial and Extracranial Cerebral Vascular Disease, MP-DE-1056 for additional requirements. Prior authorization is required. Please refer to Endovascular Procedures for Intracranial and Extracranial
performed, and radiological supervision and interpretation; without distal embodic protection interpretation; without distal embodic protection. Transcatheter placement of intravascular stent(s), intrathoracic common carotid artery or innorninate artery, open or percutaneous antegrade approach, including angioplasty, when performed, and radiological supervision and interpretation Selective catheter placement, each intracranial branch of the internal carotid or vertebral arteries, unilateral, with angiography of the selected vessel circulation and all associated radiological supervision and		Cerebral Vascular Disease, MP-DE-1056 for additional requirements. Prior authorization is required. Please refer to Endovascular Procedures for Intracranial and Extracranial Cerebral Vascular Disease, MP-DE-1056 for additional requirements. Prior authorization is required. Please refer to Endovascular Procedures for Intracranial and Extracranial
performed, and radiological supervision and interpretation; without distal embodic protection interpretation; without distal embodic protection. Transcatheter placement of intravascular stent(s), Intrathoracic common carotid artery reinominate artery, open or percutaneous antegrade approach, including angioplasty, when performed, and radiological supervision and interpretation. Selective catheter placement, each intracranial branch of the internal carotid or vertebral arteries, unilateral, with angiography of the selected vessel circulation and all associated radiological supervision and interpretation (eg. middle cerebral artery, posterior inferior creebellar artery) (List		Cerebral Vascular Disease, MP-DE-1056 for additional requirements. Prior authorization is required. Please refer to Endovascular Procedures for Intracranial and Extracranial Cerebral Vascular Disease, MP-DE-1056 for additional requirements. Prior authorization is required. Please refer to Endovascular Procedures for Intracranial and Extracranial
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performed, and radiological supervision and interpretation, without distal embidic protection interpretation, without distal embidic protection. Transcatheter placement of intravascular sten(s), intrathoracic common carolid artery or innominate artery, open or percutaneous antegrade approach, including angioplasty, when performed, and radiological supervision and interpretation (see a consideration of the internal carolid or vertebral arteries, unilateral, with angiography of the selected vessel circulation and all associated radiological supervision and interpretation (e.g. middle cerebral artery, posterior inferior cerebellar artery), (List separately in addition to code for primary procedure) Surgical Treatment of Varicose Veins Endovenous catheter directed chemical ablation with balloon isolation of incompetent externity view, open or perculaneous,	36228 Codes	Cerebral Vascular Disease, MP-DE-1056 for additional requirements. Prior authorization is required. Please refer to Endovascular Procedures for Intracranial and Extracranial Cerebral Vascular Disease, MP-DE-1056 for additional requirements. Prior authorization is required. Please refer to Endovascular Procedures for Intracranial and Extracranial Cerebral Vascular Disease, MP-DE-1056 for additional requirements.
performed, and radiological supervision and interpretation; without distal embodic protection interpretation; without distal embodic protection. Transcatheter placement of intravascular sten(s), Intrathoracic common carotid artery framework of the protection of th	36228 Codes	Cerebral Vascular Disease, MP-DE-1056 for additional requirements. Prior authorization is required. Please refer to Endovascular Procedures for Intracranial and Extracranial Cerebral Vascular Disease, MP-DE-1056 for additional requirements. Prior authorization is required. Please refer to Endovascular Procedures for Intracranial and Extracranial Cerebral Vascular Disease, MP-DE-1056 for additional requirements. Prior Authorization Requirement Prior authorization is required. Please refer to Surgical Treatment of Varicose Veins, MP-DE-1100 for
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Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to	36466	Prior authorization is required. Please refer to Surgical Treatment of Varicose Veins, MP-DE-1100 for
guide dispersion of the injectate, inclusive of		additional requirements.
all imaging guidance and monitoring; multiple incompetent truncal veins (eg, great		
saphenous vein, accessory saphenous vein),		
same leg Injection(s) of sclerosant for spider veins	36468	Drier authorization is required. Please refer to Surgical Treatment of Variance Voice, MD DE 1100 for
(telangiectasia), limb or trunk	30408	Prior authorization is required. Please refer to Surgical Treatment of Varicose Veins, MP-DE-1100 for additional requirements.
Injection of sclerosant; single incompetent	36470	Prior authorization is required. Please refer to Surgical Treatment of Varicose Veins, MP-DE-1100 for
vein (other than telangiectasia) Injection of sclerosant; multiple incompetent	2007	additional requirements.
veins (other than telangiectasia), same leg	36471	Prior authorization is required. Please refer to Surgical Treatment of Varicose Veins, MP-DE-1100 for additional requirements.
Endovenous ablation therapy of incompetent	36473	Prior authorization is required. Please refer to Surgical Treatment of Varicose Veins, MP-DE-1100 for
vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous,		additional requirements.
mechanochemical; first vein treated		
Endovenous ablation therapy of incompetent	36474	Prior authorization is required. Please refer to Surgical Treatment of Varicose Veins, MP-DE-1100 for
vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous,		additional requirements.
mechanochemical; subsequent vein(s)		
treated in a single extremity, each through separate access sites (List separately in		
addition to code for primary procedure)		
Endovenous ablation therapy of incompetent	36475	Prior authorization is required. Please refer to Surgical Treatment of Varicose Veins, MP-DE-1100 for
vein, extremity, inclusive of all imaging		additional requirements.
guidance and monitoring, percutaneous, radiofrequency; first vein treated		
Endovenous ablation therapy of incompetent	26476	Discount of the signature is a serviced. Discount of the Country of Transfer on the State of Marie of
vein, extremity, inclusive of all imaging	36476	Prior authorization is required. Please refer to Surgical Treatment of Varicose Veins, MP-DE-1100 for additional requirements.
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)		
Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging	36478	Prior authorization is required. Please refer to Surgical Treatment of Varicose Veins, MP-DE-1100 for additional requirements.
guidance and monitoring, percutaneous,		additional requirements.
laser; first vein treated Endovenous ablation therapy of incompetent	36479	Prior authorization is required. Please refer to Surgical Treatment of Varicose Veins, MP-DE-1100 for
vein, extremity, inclusive of all imaging		additional requirements.
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)		
Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a		Prior authorization is required. Please refer to Surgical Treatment of Varicose Veins, MP-DE-1100 for
chemical adhesive (eg, cyanoacrylate)		additional requirements.
remote from the access site, inclusive of all imaging guidance and monitoring,		
percutaneous; first vein treated		
Endovenous ablation therapy of incompetent	36483	Prior authorization is required. Please refer to Surgical Treatment of Varicose Veins, MP-DE-1100 for
vein, extremity, by transcatheter delivery of a	30403	additional requirements.
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)		
code for primary procedure)		
Vascular endoscopy, surgical, with ligation of perforator veins, subfascial (SEPS)	37500	Prior authorization is required. Please refer to Surgical Treatment of Varicose Veins, MP-DE-1100 for
Ligation and division of long saphenous vein	37700	additional requirements. Prior authorization is required. Please refer to Surgical Treatment of Varicose Veins, MP-DE-1100 for
at saphenofemoral junction, or distal		additional requirements.
interruptions Ligation, division, and stripping, short	37718	Prior authorization is required. Please refer to Surgical Treatment of Varicose Veins, MP-DE-1100 for
saphenous vein		additional requirements.
Ligation, division, and stripping, long (greater) saphenous veins from saphenofemoral	37722	Prior authorization is required. Please refer to Surgical Treatment of Varicose Veins, MP-DE-1100 for
junction to knee or below		additional requirements.
Ligation and division and complete stripping		
or long or short saphenous veins with radical	37735	Prior authorization is required. Please refer to Surgical Treatment of Varicose Veins, MP-DE-1100 for
of long or short saphenous veins with radical excision of ulcer and skin graft and/or	3//35	Prior authorization is required. Please refer to Surgical Treatment of Varicose Veins, MP-DE-1100 for additional requirements.
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PriMatrix, per sq cm	Q4110	Prior authorization is required. Please refer to Skin Replacement Therapy For Chronic Non healing Wounds in
		The Outpatient Setting, MP-DE-1132 for additional requirements.
GammaGraft, per sq cm	Q4111	Prior authorization is required. Please refer to Skin Replacement Therapy For Chronic Non healing Wounds in The Outpatient Setting, MP-DE-1132 for additional requirements.
Cymetra, injectable, 1 cc	Q4112	Prior authorization is required. Please refer to Skin Replacement Therapy For Chronic Non healing Wounds in The Outpatient Setting, MP-DE-1132 for additional requirements.
GRAFTJACKET XPRESS, injectable, 1 cc	Q4113	Prior authorization is required. Please refer to Skin Replacement Therapy For Chronic Non healing Wounds in The Outpatient Setting, MP-DE-1132 for additional requirements.
AlloSkin, per sq cm	Q4115	Prior authorization is required. Please refer to Skin Replacement Therapy For Chronic Non healing Wounds in
HYALOMATRIX, per sq cm	Q4117	The Outpatient Setting, MP-DE-1132 for additional requirements. Prior authorization is required. Please refer to Skin Replacement Therapy For Chronic Non healing Wounds in
MatriStem micromatrix, 1 mg	04118	The Outpatient Setting, MP-DE-1132 for additional requirements. Prior authorization is required. Please refer to Skin Replacement Therapy For Chronic Non healing Wounds in
DermACELL. DermACELL AWM or		The Outpatient Setting, MP-DE-1132 for additional requirements.
DermACELL AWM Porous, per sq cm	Q4122	Prior authorization is required. Please refer to Skin Replacement Therapy For Chronic Non healing Wounds in The Outpatient Setting, MP-DE-1132 for additional requirements.
AlloSkin RT, per sq cm	Q4123	Prior authorization is required. Please refer to Skin Replacement Therapy For Chronic Non healing Wounds in The Outpatient Setting, MP-DE-1132 for additional requirements.
OASIS ultra tri-layer wound matrix, per sq cm	Q4124	Prior authorization is required. Please refer to Skin Replacement Therapy For Chronic Non healing Wounds in The Outpatient Setting, MP-DE-1132 for additional requirements.
ArthroFlex, per sq cm	Q4125	Prior authorization is required. Please refer to Skin Replacement Therapy For Chronic Non healing Wounds in
MemoDerm, DermaSpan, TranZgraft or	Q4126	The Outpatient Setting, MP-DE-1132 for additional requirements. Prior authorization is required. Please refer to Skin Replacement Therapy For Chronic Non healing Wounds in
InteguPly, per sq cm Talymed, per sq cm	Q4127	The Outpatient Setting, MP-DE-1132 for additional requirements. Prior authorization is required. Please refer to Skin Replacement Therapy For Chronic Non healing Wounds in
HMatrix, per sq cm	Q4134	The Outpatient Setting, MP-DE-1132 for additional requirements. Prior authorization is required. Please refer to Skin Replacement Therapy For Chronic Non healing Wounds in
		The Outpatient Setting, MP-DE-1132 for additional requirements.
Mediskin, per sq cm	Q4135	Prior authorization is required. Please refer to Skin Replacement Therapy For Chronic Non healing Wounds in The Outpatient Setting, MP-DE-1132 for additional requirements.
E-Z Derm, per sq cm	Q4136	Prior authorization is required. Please refer to Skin Replacement Therapy For Chronic Non healing Wounds in The Outpatient Setting, MP-DE-1132 for additional requirements.
AmnioExcel, AmnioExcel Plus or BioDExcel, per sq cm	Q4137	Prior authorization is required. Please refer to Skin Replacement Therapy For Chronic Non healing Wounds in The Outpatient Setting, MP-DE-1132 for additional requirements.
BioDFence DryFlex, per sq cm	Q4138	Prior authorization is required. Please refer to Skin Replacement Therapy For Chronic Non healing Wounds in
AmnioMatrix or BioDMatrix, injectable, 1 cc	Q4139	The Outpatient Setting, MP-DE-1132 for additional requirements. Prior authorization is required. Please refer to Skin Replacement Therapy For Chronic Non healing Wounds in
BioDFence, per sq cm	Q4140	The Outpatient Setting, MP-DE-1132 for additional requirements. Prior authorization is required. Please refer to Skin Replacement Therapy For Chronic Non healing Wounds in
		The Outpatient Setting, MP-DE-1132 for additional requirements.
AlloSkin AC, per sq cm	Q4141	Prior authorization is required. Please refer to Skin Replacement Therapy For Chronic Non healing Wounds in The Outpatient Setting, MP-DE-1132 for additional requirements.
XCM biologic tissue matrix, per sq cm	Q4142	Prior authorization is required. Please refer to Skin Replacement Therapy For Chronic Non healing Wounds in The Outpatient Setting, MP-DE-1132 for additional requirements.
Repriza, per sq cm	Q4143	Prior authorization is required. Please refer to Skin Replacement Therapy For Chronic Non healing Wounds in The Outpatient Setting, MP-DE-1132 for additional requirements.
EpiFix, injectable, 1 mg	Q4145	Prior authorization is required. Please refer to Skin Replacement Therapy For Chronic Non healing Wounds in
Tensix, per sq cm	Q4146	The Outpatient Setting, MP-DE-1132 for additional requirements. Prior authorization is required. Please refer to Skin Replacement Therapy For Chronic Non healing Wounds in
Architect, Architect PX, or Architect FX,	Q4147	The Outpatient Setting, MP-DE-1132 for additional requirements. Prior authorization is required. Please refer to Skin Replacement Therapy For Chronic Non healing Wounds in
extracellular matrix, per sq cm Neox Cord 1K, Neox Cord RT, or Clarix Cord	Q4148	The Outpatient Setting, MP-DE-1132 for additional requirements. Prior authorization is required. Please refer to Skin Replacement Therapy For Chronic Non healing Wounds in
1K, per sq cm Excellagen, 0.1 cc	Q4149	The Outpatient Setting, MP-DE-1132 for additional requirements. Prior authorization is required. Please refer to Skin Replacement Therapy For Chronic Non healing Wounds in
AlloWrap DS or dry, per sq cm	Q4150	The Outpatient Setting, MP-DE-1132 for additional requirements. Prior authorization is required. Please refer to Skin Replacement Therapy For Chronic Non healing Wounds in
		The Outpatient Setting, MP-DE-1132 for additional requirements.
AmnioBand or Guardian, per sq cm	Q4151	Prior authorization is required. Please refer to Skin Replacement Therapy For Chronic Non healing Wounds in The Outpatient Setting, MP-DE-1132 for additional requirements.
Dermavest and Plurivest, per sq cm	Q4153	Prior authorization is required. Please refer to Skin Replacement Therapy For Chronic Non healing Wounds in The Outpatient Setting, MP-DE-1132 for additional requirements.
Neox Flo or Clarix Flo 1 mg	Q4155	Prior authorization is required. Please refer to Skin Replacement Therapy For Chronic Non healing Wounds in The Outpatient Setting, MP-DE-1132 for additional requirements.
Neox 100 or Clarix 100, per sq cm	Q4156	Prior authorization is required. Please refer to Skin Replacement Therapy For Chronic Non healing Wounds in
Revitalon, per sq cm	Q4157	The Outpatient Setting, MP-DE-1132 for additional requirements. Prior authorization is required. Please refer to Skin Replacement Therapy For Chronic Non healing Wounds in
Kerecis Omega3, per sq cm	Q4158	The Outpatient Setting, MP-DE-1132 for additional requirements. Prior authorization is required. Please refer to Skin Replacement Therapy For Chronic Non healing Wounds in
Affinity, per sq cm	Q4159	The Outpatient Setting, MP-DE-1132 for additional requirements. Prior authorization is required. Please refer to Skin Replacement Therapy For Chronic Non healing Wounds in
Nushield, per sq cm	Q4160	The Outpatient Setting, MP-DE-1132 for additional requirements. Prior authorization is required. Please refer to Skin Replacement Therapy For Chronic Non healing Wounds in
		The Outpatient Setting, MP-DE-1132 for additional requirements.
bio-ConneKt wound matrix, per sq cm	Q4161	Prior authorization is required. Please refer to Skin Replacement Therapy For Chronic Non healing Wounds in The Outpatient Setting, MP-DE-1132 for additional requirements.
WoundEx Flow, BioSkin Flow, 0.5 cc	Q4162	Prior authorization is required. Please refer to Skin Replacement Therapy For Chronic Non healing Wounds in The Outpatient Setting, MP-DE-1132 for additional requirements.
WoundEx, BioSkin, per sq cm	Q4163	Prior authorization is required. Please refer to Skin Replacement Therapy For Chronic Non healing Wounds in The Outpatient Setting, MP-DE-1132 for additional requirements.
Injection(s), platelet rich plasma, any site, including image guidance, harvesting and	0232T	Prior authorization is required. Please refer to Skin Replacement Therapy For Chronic Non healing Wounds in
preparation when performed Percutaneous Left Atrial Appendage	Codes	The Outpatient Setting, MP-DE-1132 for additional requirements. Prior Authorization Requirement
Closure (LAAC) Device		·
Percutaneous transcatheter closure of the left atrial appendage with endocardial implant, including fluoroscopy, transseptal puncture, catheter placement(s), left atrial angiography, left atrial appendage angiography, when performed, and radiological supervision and interpretation	33340	Prior authorization is required. Please refer to Percutaneous Left Atrial Appendage Closure (LAAC) Device, MP- DE-1151 for additional requirements.
Physician Certification and Recertification of Home Health Services	Codes	Prior Authorization Requirement
neces discation of nome Health Services		

Initial hospital care, per day, for the evaluation and management of a patient, which requires these \$ key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or 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 patient's and/or family's needs. Usually, the problem(s) requiring admission are of high sevently. Typically, 70 minutes are spent at the bedside and on the patient's hospital floor or unit.	99223	Prior authorization is required. Please refer to Physician Certification and Recertification of Home Health Services, MP-DE-1143 for additional requirements.
unit. Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: Problem focused cinterval history, Problem focused carmination; Medical decision making that is straightforward or of low complexity. Counseling and/or 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 patient's and/or family's needs. Usually, the patient is stable, recovering, or improving, Typically, 15 minutes are spent at the bedside and on the patient's hospital floor or unit.	99224	Prior authorization is required. Please refer to Physician Certification and Recertification of Home Health Services, MP-DE-1143 for additional requirements.
Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history. An expanded problem focused examination; Medical decision making of moderate complexity. Counseling and/or 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 patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Typically, 25 minutes are spent at the bedside and on the patient's nospatil foror or unit.	99225	Prior authorization is required. Please refer to Physician Certification and Recertification of Home Health Services, MP-DE-1143 for additional requirements.
Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history: A detailed examination; Medical decision making of high complexity. Counseling and/or 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 patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Typically, 35 minutes are spent at the bedside and on the patient's hospital floor or unit.	99226	Prior authorization is required. Please refer to Physician Certification and Recertification of Home Health Services, MP-DE-1143 for additional requirements.
Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A problem focused interval history. A problem focused examination; Medical decision making that is straightforward or of low complexity. Counseling and/or 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 patient's and/or family's needs. Usually, the patient is stable, recovering or improving, Typically, 15 minutes are spent at the bedside and on the patient's hospital floor or unit.	99231	Prior authorization is required. Please refer to Physician Certification and Recertification of Home Health Services, MP-DE-1143 for additional requirements.
Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components. An expanded problem focused interval history, An expanded problem focused interval history, An expanded problem focused examination; Medical decision making of moderate complexity. Counselling and/or 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 patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Typically, 25 minutes are spent at the bedside and on the patient's respect and on the patient's nospital floor or unit.	99232	Prior authorization is required. Please refer to Physician Certification and Recertification of Home Health Services, MP-DE-1143 for additional requirements.
Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history: A detailed examination; Medical decision making of high complexity. Counseling and/or 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 patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Typicially, 35 minutes are spent at the bedside and on the patient's hospital floor or unit.	99233	Prior authorization is required. Please refer to Physician Certification and Recertification of Home Health Services, MP-DE-1143 for additional requirements.

Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the		
evaluation and management of a patient including admission and discharge on the	99234	Prior authorization is required. Please refer to Physician Certification and Recertification of Home Health
including admission and discharge on the		Services, MP-DE-1143 for additional requirements.
same date, which requires these 3 key		
components: A detailed or comprehensive		
history; A detailed or comprehensive		
examination; and Medical decision making		
that is straightforward or of low complexity.		
Counseling and/or 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 patient's and/or family's needs.		
Usually the presenting problem(s) requiring		
admission are of low severity. Typically, 40		
minutes are spent at the bedside and on the		
patient's hospital floor or unit.		
Observation or inpatient hospital care, for the	99235	Prior authorization is required. Please refer to Physician Certification and Recertification of Home Health
evaluation and management of a patient		Services, MP-DE-1143 for additional requirements.
including admission and discharge on the		
same date, which requires these 3 key		
components: A comprehensive history; A		
comprehensive examination; and Medical		
decision making of moderate complexity.		
Counseling and/or 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 patient's and/or family's needs.		
Usually the presenting problem(s) requiring		
admission are of moderate severity.	1	
Typically, 50 minutes are spent at the		
bedside and on the patient's hospital floor or		
unit.	 	
Observation or inpatient hospital care, for the	99236	Prior authorization is required. Please refer to Physician Certification and Recertification of Home Health
evaluation and management of a patient		Services, MP-DE-1143 for additional requirements.
including admission and discharge on the	1	
same date, which requires these 3 key		
components: A comprehensive history; A		
comprehensive examination; and Medical		
decision making of high complexity.		
Counseling and/or coordination of care with	1	
other physicians, other qualified health care		
professionals, or agencies are provided		
consistent with the nature of the problem(s)		
and the patient's and/or family's needs.		
Usually the presenting problem(s) requiring		
admission are of high severity. Typically, 55		
minutes are spent at the bedside and on the		
patient's hospital floor or unit.		
Hospital discharge day management; 30	99238	Prior authorization is required. Please refer to Physician Certification and Recertification of Home Health
minutes or less		Services, MP-DE-1143 for additional requirements.
Hospital discharge day management; more	99239	Prior authorization is required. Please refer to Physician Certification and Recertification of Home Health
than 30 minutes	33233	Services, MP-DE-1143 for additional requirements.
Initial nursing facility care, per day, for the	99304	Prior authorization is required. Please refer to Physician Certification and Recertification of Home Health
evaluation and management of a patient,		Services, MP-DE-1143 for additional requirements.
which requires these 3 key components: A		
detailed or comprehensive history; A detailed		
or comprehensive examination; and Medical		
decision making that is straightforward or of		
low complexity. Counseling and/or		
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 patient's		
and/or family's needs. Usually, the problem(s) requiring admission are of low severity.		
Typically, 25 minutes are spent at the		
bedside and on the patient's facility floor or		
unit.		
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Subsequent nursing facility care, per day, for the evaluation and management of a patient,	99308	Prior authorization is required. Please refer to Physician Certification and Recertification of Home Health
which requires at least 2 of these 3 key		Services, MP-DE-1143 for additional requirements.
components: An expanded problem focused		
interval history; An expanded problem		
focused examination; Medical decision making of low complexity. Counseling and/or		
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 patient's		
and/or family's needs. Usually, the patient is		
responding inadequately to therapy or has		
developed a minor complication. Typically, 15		
minutes are spent at the bedside and on the patient's facility floor or unit.		
patient's facility noor or unit.		
Subsequent nursing facility care, per day, for	99309	Prior authorization is required. Please refer to Physician Certification and Recertification of Home Health
the evaluation and management of a patient,		Services, MP-DE-1143 for additional requirements.
which requires at least 2 of these 3 key components: A detailed interval history; A		
detailed examination; Medical decision		
making of moderate complexity. Counseling		
and/or 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 patient's and/or family's needs.		
Usually, the patient has developed a		
significant complication or a significant new problem. Typically, 25 minutes are spent at		
the bedside and on the patient's facility floor		
or unit.		
Subsequent nursing facility care, per day, for	99310	Prior authorization is required. Please refer to Physician Certification and Recertification of Home Health
the evaluation and management of a patient, which requires at least 2 of these 3 key		Services, MP-DE-1143 for additional requirements.
components: A comprehensive interval		
history; A comprehensive examination;		
Medical decision making of high complexity. Counseling and/or 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 patient's and/or family's needs. The		
patient may be unstable or may have developed a significant new problem requiring		
immediate physician attention. Typically, 35		
minutes are spent at the bedside and on the		
patient's facility floor or unit.		
Evaluation and management of a patient	99318	Prior authorization is required. Please refer to Physician Certification and Recertification of Home Health
involving an annual nursing facility	33310	Services, MP-DE-1143 for additional requirements.
assessment, which requires these 3 key		Screen, in Sec. 1243 for additional requirements.
components: A detailed interval history; A		
comprehensive examination; and Medical decision making that is of low to moderate		
complexity. Counseling and/or 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 patient's and/or family's		
needs. Usually, the patient is stable,		
recovering, or improving. Typically, 30		
minutes are spent at the bedside and on the		
patient's facility floor or unit. Home visit for the evaluation and	00244	Daise and beside in a service of Discoveries to Description Contribution and Description (1) and the Discoveries to Description (1) and the Discoveries (1) and the Discoverie
management of a new patient, which requires	99341	Prior authorization is required. Please refer to Physician Certification and Recertification of Home Health Services, MP-DE-1143 for additional requirements.
these 3 key components: A problem focused		3et vices, ivir-be-1143 for additional requirements.
history; A problem focused examination; and		
Straightforward medical decision making. Counseling and/or 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 patient's and/or family's needs.		
Usually, the presenting problem(s) are of low		
severity. Typically, 20 minutes are spent face	4	
to-face with the patient and/or family.		
Home visit for the evaluation and	99342	Prior authorization is required. Please refer to Physician Certification and Recertification of Home Health
management of a new patient, which requires	99342	Services, MP-DE-1143 for additional requirements.
these 3 key components: An expanded		pervices, ivii -DC-1145 ioi auditionali equifements.
problem focused history; An expanded		
problem focused examination; and Medical decision making of low complexity.		
Counseling and/or 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 patient's and/or family's needs.		
Usually, the presenting problem(s) are of		
moderate severity. Typically, 30 minutes are		
spent face-to-face with the patient and/or family.		
Home visit for the evaluation and	99343	Prior authorization is required. Please refer to Physician Certification and Recertification of Home Health
management of a new patient, which requires	333.3	Services, MP-DE-1143 for additional requirements.
these 3 key components: A detailed history;		
A detailed examination; and Medical decision making of moderate complexity. Counseling		
and/or 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 patient's and/or family's needs.		
Usually, the presenting problem(s) are of		
moderate to high severity. Typically, 45		
minutes are spent face-to-face with the		
patient and/or family.	00344	Drier authorization is required. Please refer to Physician Contification and Promotification of the Continue o
Home visit for the evaluation and management of a new patient, which requires	99344	Prior authorization is required. Please refer to Physician Certification and Recertification of Home Health
these 3 key components: A comprehensive		Services, MP-DE-1143 for additional requirements.
history; A comprehensive examination; and		
Medical decision making of moderate		
complexity. Counseling and/or coordination of care with other physicians, other qualified		
health care professionals, or agencies are		
provided consistent with the nature of the		
	I	
problem(s) and the patient's and/or family's		
needs. Usually, the presenting problem(s) are		
needs. Usually, the presenting problem(s) are of high severity. Typically, 60 minutes are		
needs. Usually, the presenting problem(s) are		

	T	To
Home visit for the evaluation and management of a new patient, which requires	99345	Prior authorization is required. Please refer to Physician Certification and Recertification of Home Health Services, MP-DE-1143 for additional requirements.
these 3 key components: A comprehensive history; A comprehensive examination; and		
Medical decision making of high complexity.		
Counseling and/or 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 patient's and/or family's needs.		
Usually, the patient is unstable or has		
developed a significant new problem requiring immediate physician attention. Typically, 75		
minutes are spent face-to-face with the		
patient and/or family.	00247	
Home visit for the evaluation and management of an established patient, which	99347	Prior authorization is required. Please refer to Physician Certification and Recertification of Home Health Services, MP-DE-1143 for additional requirements.
requires at least 2 of these 3 key		Services, in SE 12-5 for additional requirements.
components: A problem focused interval history; A problem focused examination;		
Straightforward medical decision making. Counseling and/or 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 patient's and/or family's needs.		
Usually, the presenting problem(s) are self		
limited or minor. Typically, 15 minutes are spent face-to-face with the patient and/or		
family.		
Home visit for the evaluation and management of an established patient, which	99348	Prior authorization is required. Please refer to Physician Certification and Recertification of Home Health
requires at least 2 of these 3 key		Services, MP-DE-1143 for additional requirements.
components: An expanded problem focused interval history; An expanded problem		
focused examination; Medical decision		
making of low complexity. Counseling and/or 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 patient's		
and/or family's needs. Usually, the presenting		
problem(s) are of low to moderate severity. Typically, 25 minutes are spent face-to-face		
with the patient and/or family.		
	20240	
Home visit for the evaluation and management of an established patient, which	99349	Prior authorization is required. Please refer to Physician Certification and Recertification of Home Health Services, MP-DE-1143 for additional requirements.
requires at least 2 of these 3 key		Services, IVII -DE-1145 for additional requirements.
components: A detailed interval history; A detailed examination: Medical decision		
making of moderate complexity. Counseling		
and/or 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 patient's and/or family's needs.		
Usually, the presenting problem(s) are		
moderate to high severity. Typically, 40		
minutes are spent face-to-face with the patient and/or family.		
Home visit for the evaluation and	99350	Prior authorization is required. Please refer to Physician Certification and Recertification of Home Health
management of an established patient, which requires at least 2 of these 3 key		Services, MP-DE-1143 for additional requirements.
components: A comprehensive interval		
history; A comprehensive examination; Medical decision making of moderate to high		
complexity. Counseling and/or 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 patient's and/or family's		
needs. Usually, the presenting problem(s) are of moderate to high severity. The patient may		
be unstable or may have developed a		
significant new problem requiring immediate physician attention. Typically, 60 minutes are		
spent face-to-face with the patient and/or		
family. External Hearing Aids, Auditory	Codes	Prior Authorization Requirement
Brainstem Implant, Bone-Anchored	coucs	The Additionation requirement
Hearing Devices and Audiological Testing		
Contestant for evaluation of hosts to	54520	Delicate the single in the sin
Craniectomy for excision of brain tumor, infratentorial or posterior fossa;	61520	Prior authorization is required. Please refer to External Hearing Aids, Auditory Brainstem Implant, Bone- Anchored Hearing Devices and Audiological Testing, MP-DE-1190 for additional requirements.
cerebellopontine angle tumor	54520	
Craniectomy, bone flap craniotomy, transtemporal (mastoid) for excision of	61530	Prior authorization is required. Please refer to External Hearing Aids, Auditory Brainstem Implant, Bone- Anchored Hearing Devices and Audiological Testing, MP-DE-1190 for additional requirements.
cerebellopontine angle tumor; combined with		Authorica recarring previous and Audiological resumg, INF PET 130 for additional requirements.
middle/posterior fossa craniotomy/craniectomy		
Transpetrosal approach to posterior cranial	61598	Prior authorization is required. Please refer to External Hearing Aids, Auditory Brainstem Implant, Bone-
fossa, clivus or foramen magnum, including ligation of superior petrosal sinus and/or		Anchored Hearing Devices and Audiological Testing, MP-DE-1190 for additional requirements.
sigmoid sinus	50744	
Implantation, osseointegrated implant, skull; with percutaneous attachment to external	69714	Prior authorization is required. Please refer to External Hearing Aids, Auditory Brainstem Implant, Bone- Anchored Hearing Devices and Audiological Testing, MP-DE-1190 for additional requirements.
speech processor	hrono	
HEAR AID MONAURL BDY WRN AIR CONDCT	V5030	Prior authorization is required for billed charges greater than \$500. Please refer to External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing, MP-DE-1190 for
CONDCI		additional requirements.
HEAR AID MONAURL BDY WORN BN		Prior authorization is required for billed charges greater than \$500. Please refer to External Hearing Aids,
	V5040	
CONDCT	V5040	Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing, MP-DE-1190 for
		Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing, MP-DE-1190 for additional requirements.
CONDCT HEARING AID MONAURAL IN THE EAR	V5050	Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing, MP-DE-1190 for additional requirements. Prior authorization is required for billed charges greater than \$500. Please refer to External Hearing Alds,
		Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing, MP-DE-1190 for additional requirements.
	V5050	Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing, MP-DE-1190 for additional requirements. Prior authorization is required for billed charges greater than \$500. Please refer to External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing, MP-DE-1190 for additional requirements. Prior authorization is required for billed charges greater than \$500. Please refer to External Hearing Aids,
HEARING AID MONAURAL IN THE EAR	V5050	Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing, MP-DE-1190 for additional requirements. Prior authorization is required for billed charges greater than \$500. Please refer to External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing, MP-DE-1190 for additional requirements. Prior authorization is required for billed charges greater than \$500. Please refer to External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing, MP-DE-1190 for
HEARING AID MONAURAL IN THE EAR HEARING AID MONAURAL BEHIND THE EAR	V5050 V5060	Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing, MP-DE-1190 for additional requirements. Prior authorization is required for billed charges greater than \$500. Please refer to External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing, MP-DE-1190 for additional requirements. Prior authorization is required for billed charges greater than \$500. Please refer to External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing, MP-DE-1190 for additional requirements.
HEARING AID MONAURAL IN THE EAR	V5050	Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing, MP-DE-1190 for additional requirements. Prior authorization is required for billed charges greater than \$500. Please refer to External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing, MP-DE-1190 for additional requirements. Prior authorization is required for billed charges greater than \$500. Please refer to External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing, MP-DE-1190 for additional requirements. Prior authorization is required for billed charges greater than \$500. Please refer to External Hearing Aids,
HEARING AID MONAURAL IN THE EAR HEARING AID MONAURAL BEHIND THE EAR	V5050 V5060	Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing, MP-DE-1190 for additional requirements. Prior authorization is required for billed charges greater than \$500. Please refer to External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing, MP-DE-1190 for additional requirements. Prior authorization is required for billed charges greater than \$500. Please refer to External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing, MP-DE-1190 for additional requirements.
HEARING AID MONAURAL IN THE EAR HEARING AID MONAURAL BEHIND THE EAR	V5050 V5060	Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing, MP-DE-1190 for additional requirements. Prior authorization is required for billed charges greater than \$500. Please refer to External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing, MP-DE-1190 for additional requirements. Prior authorization is required for billed charges greater than \$500. Please refer to External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing, MP-DE-1190 for additional requirements. Prior authorization is required for billed charges greater than \$500. Please refer to External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing, MP-DE-1190 for additional requirements. Prior authorization is required for billed charges greater than \$500. Please refer to External Hearing Aids, Prior authorization is required for billed charges greater than \$500. Please refer to External Hearing Aids, Prior authorization is required for billed charges greater than \$500. Please refer to External Hearing Aids,
HEARING AID MONAURAL IN THE EAR HEARING AID MONAURAL BEHIND THE EAR GLASSES AIR CONDUCTION	V5050 V5060 V5070	Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing, MP-DE-1190 for additional requirements. Prior authorization is required for billed charges greater than \$500. Please refer to External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing, MP-DE-1190 for additional requirements. Prior authorization is required for billed charges greater than \$500. Please refer to External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing, MP-DE-1190 for additional requirements. Prior authorization is required for billed charges greater than \$500. Please refer to External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing, MP-DE-1190 for additional requirements. Prior authorization is required for billed charges greater than \$500. Please refer to External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing, MP-DE-1190 for additional requirements.
HEARING AID MONAURAL IN THE EAR HEARING AID MONAURAL BEHIND THE EAR GLASSES AIR CONDUCTION GLASSES BONE CONDUCTION	V5050 V5060 V5070	Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing, MP-DE-1190 for additional requirements. Prior authorization is required for billed charges greater than \$500. Please refer to External Hearing Alds, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing, MP-DE-1190 for additional requirements. Prior authorization is required for billed charges greater than \$500. Please refer to External Hearing Alds, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing, MP-DE-1190 for additional requirements. Prior authorization is required for billed charges greater than \$500. Please refer to External Hearing Alds, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing, MP-DE-1190 for additional requirements. Prior authorization is required for billed charges greater than \$500. Please refer to External Hearing Alds, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing, MP-DE-1190 for additional requirements.
HEARING AID MONAURAL IN THE EAR HEARING AID MONAURAL BEHIND THE EAR GLASSES AIR CONDUCTION	V5050 V5060 V5070	Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing, MP-DE-1190 for additional requirements. Prior authorization is required for billed charges greater than \$500. Please refer to External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing, MP-DE-1190 for additional requirements. Prior authorization is required for billed charges greater than \$500. Please refer to External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing, MP-DE-1190 for additional requirements. Prior authorization is required for billed charges greater than \$500. Please refer to External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing, MP-DE-1190 for additional requirements. Prior authorization is required for billed charges greater than \$500. Please refer to External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing, MP-DE-1190 for additional requirements.
HEARING AID MONAURAL IN THE EAR HEARING AID MONAURAL BEHIND THE EAR GLASSES AIR CONDUCTION GLASSES BONE CONDUCTION	V5050 V5060 V5070	Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing, MP-DE-1190 for additional requirements. Prior authorization is required for billed charges greater than \$500. Please refer to External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing, MP-DE-1190 for additional requirements. Prior authorization is required for billed charges greater than \$500. Please refer to External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing, MP-DE-1190 for additional requirements. Prior authorization is required for billed charges greater than \$500. Please refer to External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing, MP-DE-1190 for additional requirements. Prior authorization is required for billed charges greater than \$500. Please refer to External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing, MP-DE-1190 for additional requirements. Prior authorization is required for billed charges greater than \$500. Please refer to External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing, MP-DE-1190 for additional requirements. Prior authorization is required for billed charges greater than \$500. Please refer to External Hearing Aids, Prior authorization is required for billed charges greater than \$500. Please refer to External Hearing Aids,

BINAURAL BODY	V5120	Prior authorization is required for billed charges greater than \$500. Please refer to External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing, MP-DE-1190 for additional requirements.
BINAURAL IN THE EAR	V5130	Prior authorization is required for billed charges greater than \$500. Please refer to External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing, MP-DE-1190 for additional requirements.
BINAURAL BEHIND THE EAR	V5140	Prior authorization is required for billed charges greater than \$500. Please refer to External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing, MP-DE-1190 for additional requirements.
BINAURAL GLASSES	V5150	Prior authorization is required for billed charges greater than \$500. Please refer to External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing, MP-DE-1190 for additional requirements.
HA CONTRALAT RTE DVC MONAURAL ITE	V5171	Prior authorization is required for billed charges greater than \$500. Please refer to External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing, MP-DE-1190 for additional requirements.
HA CONTRALAT RTE DVC MONAURAL ICT	V5172	Prior authorization is required for billed charges greater than \$500. Please refer to External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing, MP-DE-1190 for additional requirements.
HA CONTRALAT RTE DVC MONAURAL BTE	V5181	Prior authorization is required for billed charges greater than \$500. Please refer to External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing, MP-DE-1190 for
HA CONTRALAT RS BINAURAL ITE/ITE	V5211	additional requirements. Prior authorization is required for billed charges greater than \$500. Please refer to External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing, MP-DE-1190 for
HA CONTRALAT RS BINAURAL ITE/ITE	V5212	additional requirements. Prior authorization is required for billed charges greater than \$500. Please refer to External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing, MP-DE-1190 for
HA CONTRA RTE SYS BINAURAL ITE/ITC	V5213	additional requirements. Prior authorization is required for billed charges greater than \$500. Please refer to External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing, MP-DE-1190 for
HA CONTRA ROUT SYS BINAURAL ITE/BTE	V5214	additional requirements. Prior authorization is required for billed charges greater than \$500. Please refer to External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing, MP-DE-1190 for
HA CONTRA ROUT SYS BINAURAL ITC/ITC	V5215	additional requirements. Prior authorization is required for billed charges greater than \$500. Please refer to External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing, MP-DE-1190 for
HA CONTRA ROUT SYS BINAURAL ITC/BTE	V5221	additional requirements. Prior authorization is required for billed charges greater than \$500. Please refer to External Hearing Aids, Auditory Brainstem Implant, Sone-Anchored Hearing Devices and Audiological Testing, NP-DE-1190 for
HA CONTRALAT RTE SYS BINAUR GLASSES	V5230	additional requirements. Prior authorization is required for billed charges greater than \$500. Please refer to External Hearing Aids,
HEARING AID ANALOG MONAURAL CIC	V5242	Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing, MP-DE-1190 for additional requirements. Prior authorization is required for billed charges greater than \$500. Please refer to External Hearing Aids,
HEARING AID ANALOG MONAURAL ITC	V5243	Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing, MP-DE-1190 for additional requirements. Prior authorization is required for billed charges greater than \$500. Please refer to External Hearing Aids,
HEARING AID PROG ANALOG MONAURL	V5244	Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing, MP-DE-1190 for additional requirements. Prior authorization is required for billed charges greater than \$500. Please refer to External Hearing Aids,
CIC		Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing, MP-DE-1190 for additional requirements.
HEARING AID PROG ANALOG MONAURL ITC	V5245	Prior authorization is required for billed charges greater than \$500. Please refer to External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing, MP-DE-1190 for additional requirements.
HEARING AID PROG ANALOG MONAURL ITE	V5246	Prior authorization is required for billed charges greater than \$500. Please refer to External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing, MP-DE-1190 for additional requirements.
HEARING AID PROG ANALOG MONAURL BTE	V5247	Prior authorization is required for billed charges greater than \$500. Please refer to External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing, MP-DE-1190 for additional requirements.
HEARING AID ANALOG BINAURAL CIC	V5248	Prior authorization is required for billed charges greater than \$500. Please refer to External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing, MP-DE-1190 for additional requirements.
HEARING AID ANALOG BINAURAL ITC	V5249	Prior authorization is required for billed charges greater than \$500. Please refer to External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing, MP-DE-1190 for additional requirements.
HEARING AID PROG ANALOG BINAURL CIC	V5250	Prior authorization is required for billed charges greater than \$500. Please refer to External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing, MP-DE-1190 for additional requirements.
HEARING AID PROG ANALOG BINAURL ITC	V5251	Prior authorization is required for billed charges greater than \$500. Please refer to External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing, MP-DE-1190 for additional requirements.
HEARING AID PROG BINAURAL ITE	V5252	Prior authorization is required for billed charges greater than \$500. Please refer to External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing, MP-DE-1190 for additional requirements.
HEARING AID PROG BINAURAL BTE	V5253	adultions requirements. Prior authorization is required for billed charges greater than \$500. Please refer to External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing, MP-DE-1190 for additional requirements.
HEARING AID DIGITAL MONAURAL CIC	V5254	Prior authorization is required for billed charges greater than \$500. Please refer to External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing, MP-DE-1190 for
HEARING AID DIGITAL MONAURAL ITC	V5255	additional requirements. Prior authorization is required for billed charges greater than \$500. Please refer to External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing, MP-DE-1190 for additional requirements.
HEARING AID DIGITAL MONAURAL ITE	V5256	Prior authorization is required for billed charges greater than \$500. Please refer to External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing, MP-DE-1190 for
HEARING AID DIGITAL MONAURAL BTE	V5257	additional requirements. Prior authorization is required for billed charges greater than \$500. Please refer to External Hearing Aids, Auditory Frainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing, MP-0E-1190 for
HEARING AID DIGITAL BINAURAL CIC	V5258	additional requirements. Prior authorization is required for billed charges greater than \$500. Please refer to External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing, MP-DE-1190 for
HEARING AID DIGITAL BINAURAL ITC	V5259	additional requirements. Prior authorization is required for billed charges greater than \$500. Please refer to External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing, MP-DE-1190 for
	V5260	additional requirements. Prior authorization is required for billed charges greater than \$500. Please refer to External Hearing Aids,
HEARING AID DIGITAL BINAURAL ITE	13200	Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing, MP-DE-1190 for additional requirements.

HEARING AID DISPBL TYPE MONAURAL	V5262	Prior authorization is required for billed charges greater than \$500. Please refer to External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing, MP-DE-1190 for additional requirements.
HEARING AID DISPBL TYPE BINAURAL	V5263	Prior authorization is required for billed charges greater than \$500. Please refer to External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing, MP-DE-1190 for additional requirements.
HEARING AID NOC	V5298	additional requirements. Prior authorization is requirement. Prior authorization is required for billed charges greater than \$500. Please refer to External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing, MP-DE-1190 for additional requirements.
Hearing service, miscellaneous	V5299	Prior authorization is required for billed charges greater than \$500. Please refer to External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing, MP-DE-1190 for additional requirements.
AUDITORY OSSEOINTEGRAT DEV BDY WORN	L8692	Prior authorization is required for billed charges greater than \$500. Please refer to External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing, MP-DE-1190 for additional requirements.
SEMI-IMPL MID EAR HEARING PROSTH	V5095	Prior authorization is required for billed charges greater than \$500. Please refer to External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing, MP-DE-1190 for additional requirements.
AO D EXT SP EXCL TRNDCR/ACTR RPL EA	L8691	Prior authorization is required for billed charges greater than \$500. Please refer to External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing, MP-DE-1190 for additional requirements.
AUD OI DVC TRNSDUCR/ACTUATR REPL EA	L8694	Prior authorization is required for billed charges greater than \$500. Please refer to External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing, MP-DE-1190 for additional requirements.
Biofeedback	Codes	Prior Authorization Requirement
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	90912	Prior authorization is required. Please refer to Biofeedback, MP-DE-1193 for additional requirements.
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)	90913	Prior authorization is required. Please refer to Biofeedback, MP-DE-1193 for additional requirements.
Testing for Genetic Disease	Codes No specific codes listed	Prior Authorization Requirement Prior authorization is required. Please refer to Testing for Genetic Disease, MP-DE-1205 for additional
Genetic Testing for Colorectal Cancer	Codes	requirements. Prior Authorization Requirement
Susceptibility APC (adenomatous polyposis coli) (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; known	81202	Prior authorization is required. Please refer to Genetic Testing for Colorectal Cancer Susceptibility, MP-DE- 1207 for additional requirements.
familial variants APC (adenomatous polyposis coli) (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis;	81203	Prior authorization is required. Please refer to Genetic Testing for Colorectal Cancer Susceptibility, MP-DE- 1207 for additional requirements.
duplication/deletion variants 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	81301	Prior authorization is required. Please refer to Genetic Testing for Colorectal Cancer Susceptibility, MP-DE- 1207 for additional requirements.
tissue, if performed MOLECULAR PATHOLOGY PROCEDURE LEVEL 2	81401	Prior authorization is required. Please refer to Genetic Testing for Colorectal Cancer Susceptibility, MP-DE- 1207 for additional requirements.
Fetal Aneuploidy Testing Using Noninvasive Cell-Free Fetal DNA	Codes	Prior Authorization Requirement
Fetal chromosomal aneuploidy (eg, trisomy 21, monosomy X) genomic sequence analysis panel, circulating cell-free fetal DNA in maternal blood, must include analysis of	81420	Prior authorization is required. Please refer to Fetal Aneuploidy Testing Using Noninvasive Cell-Free Fetal DNA, MP-DE-1208 for additional requirements.
chromosomes 13, 18, and 21 Fetal aneuploidy (trisomy 21, 18, and 13) DNA sequence analysis of selected regions using maternal plasma, algorithm reported as	81507	Prior authorization is required. Please refer to Fetal Aneuploidy Testing Using Noninvasive Cell-Free Fetal DNA, MP-DE-1208 for additional requirements.
a risk score for each trisomy Chromosomal Microarray Analysis, Comparative Genomic Hybridization and Single Nucleotide Polymorphism	Codes	Prior Authorization Requirement
CYP2C9 (cytochrome P450, family 2, subfamily C, polypeptide 9) (eg, drug metabolism), gene analysis, common variants	81227	Prior authorization is required. Please refer to Chromosomal Microarray Analysis, Comparative Genomic Hybridization and Single Nucleotide Polymorphism, MP-DE-1209 for additional requirements.
(eg, 2, 3, 5, 6) Oncologic Genetic Testing Panels	Codes	Prior Authorization Requirement
MOLECULAR PATHOLOGY PROCEDURE LEVEL 1	81400	Prior authorization is required. Please refer to Oncologic Genetic Testing Panels , MP-DE-1210 for additional requirements.
MOLECULAR PATHOLOGY PROCEDURE LEVEL 2 MOLECULAR PATHOLOGY PROCEDURE	81401	Prior authorization is required. Please refer to Oncologic Genetic Testing Panels , MP-DE-1210 for additional requirements. Prior authorization is required. Please refer to Oncologic Genetic Testing Panels. MP-DE-1210 for additional prior authorization is required.
LEVEL 5 Hereditary breast cancer-related disorders	81432	Prior authorization is required. Please refer to Oncologic Genetic Testing Panels , MP-DE-1210 for additional requirements. Prior authorization is required. Please refer to Oncologic Genetic Testing Panels , MP-DE-1210 for additional
(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		requirements.
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	81433	Prior authorization is required. Please refer to Oncologic Genetic Testing Panels, MP-DE-1210 for additional requirements.
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	81437	Prior authorization is required. Please refer to Oncologic Genetic Testing Panels , MP-DE-1210 for additional requirements.
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	81438	Prior authorization is required. Please refer to Oncologic Genetic Testing Panels , MP-DE-1210 for additional requirements.
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Unlisted molecular pathology procedure	81479	Prior authorization is required. Please refer to Oncologic Genetic Testing Panels , MP-DE-1210 for additional
Oncology (tissue of origin), microarray gene	81504	requirements. Prior authorization is required. Please refer to Oncologic Genetic Testing Panels , MP-DE-1210 for additional
expression profiling of > 2000 genes, utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as tissue similarity scores		requirements.
Oncology (breast), mRNA gene expression profiling by hybrid capture of 58 genes (50 content and 8 housekeeping), utilizing formalin-fixed paraffin-embedded tissue,	81520	Prior authorization is required. Please refer to Oncologic Genetic Testing Panels , MP-DE-1210 for additional requirements.
algorithm reported as a recurrence risk score Oncology (breast), mRNA, microarray gene	81521	Prior authorization is required. Please refer to Oncologic Genetic Testing Panels , MP-DE-1210 for additional
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		requirements.
risk of distant metastasis Oncology (tumor of unknown origin), mRNA,	81540	Prior authorization is required. Please refer to Oncologic Genetic Testing Panels , MP-DE-1210 for additional
gene expression profiling by real-time RT-PCs 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		requirements.
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	81541	Prior authorization is required. Please refer to Oncologic Genetic Testing Panels , MP-DE-1210 for additional requirements.
Unlisted cytogenetic study	88299	Prior authorization is required. Please refer to Oncologic Genetic Testing Panels , MP-DE-1210 for additional
Gene expression profiling panel for use in the	53854	requirements. Prior authorization is required. Please refer to Oncologic Genetic Testing Panels , MP-DE-1210 for additional
management of breast cancer treatment Labiaplasty	Codes	requirements. Prior Authorization Requirement
Excision, excessive skin and subcutaneous	15839	Prior Authorization Requirement Prior authorization is required. Please refer to Labiaplasty, MP-DE-1215 for additional requirements.
tissue (includes lipectomy); other area Unlisted procedure, female genital system	58999	Prior authorization is required. Please refer to Labiaplasty, MP-DE-1215 for additional requirements.
(nonobstetrical) Gender Affirmation Surgeries	Codes	Prior Authorization Requirement
Construction of artificial vagina, with graft	57292	Prior authorization is required. Please refer to Gender Affirmation Services, MP-DE-1216 for additional
Revision (including removal) of prosthetic vaginal graft; vaginal approach	57295	requirements. Prior authorization is required. Please refer to Gender Affirmation Services, MP-DE-1216 for additional requirements.
Revision (including removal) of prosthetic vaginal graft; open approach	57296	Prior authorization is required. Please refer to Gender Affirmation Services, MP-DE-1216 for additional requirements.
Vaginoplasty for intersex state	57335	Prior authorization is required. Please refer to Gender Affirmation Services, MP-DE-1216 for additional requirements.
Revision (including removal) of prosthetic vaginal graft; laparoscopic approach	57426	Prior authorization is required. Please refer to Gender Affirmation Services, MP-DE-1216 for additional requirements.
Total abdominal hysterectomy (corpus and cervix), with or without removal of	58150	Prior authorization is required. Please refer to Gender Affirmation Services, MP-DE-1216 for additional requirements.
tube(s), with or without removal of ovary(s)		
Supracervical abdominal hysterectomy (subtotal hysterectomy), with or without removal of tube(s), with or without removal of ovary(s)	58180	Prior authorization is required. Please refer to Gender Affirmation Services, MP-DE-1216 for additional requirements.
Vaginal hysterectomy, for uterus 250 g or less;	58260	Prior authorization is required. Please refer to Gender Affirmation Services, MP-DE-1216 for additional requirements.
Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s)	58262	Prior authorization is required. Please refer to Gender Affirmation Services, MP-DE-1216 for additional requirements.
Vaginal hysterectomy, with total or partial vaginectomy	58275	Prior authorization is required. Please refer to Gender Affirmation Services, MP-DE-1216 for additional requirements.
Vaginal hysterectomy, for uterus greater than 250 g	58290	Prior authorization is required. Please refer to Gender Affirmation Services, MP-DE-1216 for additional requirements.
Vaginal hysterectomy, for uterus greater than 250 g with removal of tube(s)	58291	Prior authorization is required. Please refer to Gender Affirmation Services, MP-DE-1216 for additional requirements.
and/or ovary(s) Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less	58541	Prior authorization is required. Please refer to Gender Affirmation Services, MP-DE-1216 for additional requirements.
Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less;	58542	Prior authorization is required. Please refer to Gender Affirmation Services, MP-DE-1216 for additional requirements.
with removal of tube(s) and/or ovary(s) Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than	58543	Prior authorization is required. Please refer to Gender Affirmation Services, MP-DE-1216 for additional requirements.
250 g; Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than	58544	Prior authorization is required. Please refer to Gender Affirmation Services, MP-DE-1216 for additional requirements.
250 g; with removal of tube(s) and/or ovary(s) Laparoscopy, surgical, with vaginal	58550	Prior authorization is required. Please refer to Gender Affirmation Services, MP-DE-1216 for additional
hysterectomy, for uterus 250 g or less; Laparoscopy, surgical, with vaginal	58552	Prior authorization is required. Please refer to Gender Affirmation Services, MP-DE-1216 for additional requirements. Prior authorization is required. Please refer to Gender Affirmation Services, MP-DE-1216 for additional
hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)		requirements.
Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g	58553	Prior authorization is required. Please refer to Gender Affirmation Services, MP-DE-1216 for additional requirements.
Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)	58554	Prior authorization is required. Please refer to Gender Affirmation Services, MP-DE-1216 for additional requirements.
Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less	58570	Prior authorization is required. Please refer to Gender Affirmation Services, MP-DE-1216 for additional requirements.
Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)	58571	Prior authorization is required. Please refer to Gender Affirmation Services, MP-DE-1216 for additional requirements.
	58572	Prior authorization is required. Please refer to Gender Affirmation Services, MP-DE-1216 for additional
Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g		requirements.
	58573	requirements. Prior authorization is required. Please refer to Gender Affirmation Services, MP-DE-1216 for additional requirements.
hysterectomy, for uterus greater than 250 g Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or	58573 58661	Prior authorization is required. Please refer to Gender Affirmation Services, MP-DE-1216 for additional

Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)	58720	Prior authorization is required. Please refer to Gender Affirmation Services, MP-DE-1216 for additional requirements.
Oophorectomy, partial or total, unilateral or bilateral;	58940	Prior authorization is required. Please refer to Gender Affirmation Services, MP-DE-1216 for additional requirements.
Insertion of tissue expander(s) for other than breast, including subsequent expansion	11960	Prior authorization is required. Please refer to Gender Affirmation Services, MP-DE-1216 for additional requirements.
Replacement of tissue expander with permanent testicular insertion	11970	Prior authorization is required. Please refer to Gender Affirmation Services, MP-DE-1216 for additional requirements.
Adjacent tissue transfer or rearrangement, trunk; defect 10 sq. cm	14000	Prior authorization is required. Please refer to Gender Affirmation Services, MP-DE-1216 for additional requirements.
or less Adjacent tissue transfer or rearrangement, trunk; defect 10.1 sq. cm	14001	Prior authorization is required. Please refer to Gender Affirmation Services, MP-DE-1216 for additional requirements.
to 30.0 sq. cm Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands	14041	Prior authorization is required. Please refer to Gender Affirmation Services, MP-DE-1216 for additional requirements.
and/or feet; defect 10.1 sq. cm to 30.0 sq. cm Implantation of biologic implant (e.g.,	15777	Prior authorization is required. Please refer to Gender Affirmation Services, MP-DE-1216 for additional
acellular dermal matrix) for soft tissue reinforcement (i.e. breast, trunk) (List separately in addition to code for primary procedure		requirements.
Suction assisted lipectomy; head and neck	15876	Prior authorization is required. Please refer to Gender Affirmation Services, MP-DE-1216 for additional requirements.
Mastopexy	19316	Prior authorization is required. Please refer to Gender Affirmation Services, MP-DE-1216 for additional requirements.
Mammoplasty, augmentation; with prosthetic implant	19325	Prior authorization is required. Please refer to Gender Affirmation Services, MP-DE-1216 for additional requirements.
Immediate insertion of breast prosthesis following mastopexy, mastectomy (unrelated to mastectomy or post mastectomy reconstruction	19340	Prior authorization is required. Please refer to Gender Affirmation Services, MP-DE-1216 for additional requirements.
Delayed insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction	19342	Prior authorization is required. Please refer to Gender Affirmation Services, MP-DE-1216 for additional requirements.
Nipple/areola reconstruction (unrelated to mastectomy or post mastectomy reconstruction)	19350	Prior authorization is required. Please refer to Gender Affirmation Services, MP-DE-1216 for additional requirements.
Radiofrequency Ablation of Miscellaneous Solid Tumors, Excluding Liver Tumors	Codes	Prior Authorization Requirement
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	20982	Prior authorization is required. Please refer to Radiofrequency Ablation of Miscellaneous Solid Tumors, Excluding Liver Tumors, MP-DE-1218 for additional requirements.
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;	32998	Prior authorization is required. Please refer to Radiofrequency Ablation of Miscellaneous Solid Tumors, Excluding Liver Tumors, MP-DE-1218 for additional requirements.
Fradiotroguency	1	
radiofrequency Per-Oral Endoscopic Myotomy	Codes	Prior Authorization Requirement
Per-Oral Endoscopic Myotomy Unlisted procedure, esophagus	43499	Prior authorization is required. Please refer to Per-Oral Endoscopic Myotomy, MP-DE-1226 for additional requirements.
Per-Oral Endoscopic Myotomy Unlisted procedure, esophagus Transcatheter Closure Devices for Septal Defects	43499 Codes	Prior authorization is required. Please refer to Per-Oral Endoscopic Myotomy, MP-DE-1226 for additional requirements. Prior Authorization Requirement
Per-Oral Endoscopic Myotomy Unlisted procedure, esophagus Transcatheter Closure Devices for Septal Defects Percutaneous transcatheter closure of congenital interatrial communication (ie, Fortnat nenestration, atrial septal defect) with	43499	Prior authorization is required. Please refer to Per-Oral Endoscopic Myotomy, MP-DE-1226 for additional requirements.
Per-Oral Endoscopic Myotomy Unlisted procedure, esophagus Transcatheter Closure Devices for Septal Defects Percutaneous transcatheter closure of congenital interatrial communication (ie, Fortian fineastrain, artial septal defect) with implant Percutaneous transcatheter closure of a congenital ventricular septal defect with implant	43499 Codes 93580	Prior authorization is required. Please refer to Per-Oral Endoscopic Myotomy, MP-DE-1226 for additional requirements. Prior Authorization Requirement Prior authorization is required. Please refer to Transcatheter Closure Devices for Septal Defects, MP-DE-1234 for additional requirements. Prior authorization is required. Please refer to Transcatheter Closure Devices for Septal Defects, MP-DE-1234 for additional requirements.
Per-Oral Endoscopic Myotomy Unlisted procedure, esophagus Transcatheter Closure Devices for Septal Defects Percutaneous transcatheter closure of congenital interatrial communication (e, Fontan fenestration, artial septal defect) with implant. Percutaneous transcatheter closure of a congenital ventricular septal defect with implant. Percutaneous transcatheter closure of patent ductus arterioreus	43499 Codes 93580 93581	Prior authorization is required. Please refer to Per-Oral Endoscopic Myotomy, MP-DE-1226 for additional requirements. Prior Authorization Requirement Prior authorization is required. Please refer to Transcatheter Closure Devices for Septal Defects, MP-DE-1234 for additional requirements. Prior authorization is required. Please refer to Transcatheter Closure Devices for Septal Defects, MP-DE-1234 for additional requirements. Prior authorization is required. Please refer to Transcatheter Closure Devices for Septal Defects, MP-DE-1234 for additional requirements.
Per-Oral Endoscopic Myotomy Unlisted procedure, esophagus Transcatheter Closure Devices for Septal Defects Parcutaneous transcatheter closure of congenital interdiat communication (ie, Fontan fenestration, arrial septal defect) with implant. Parcutaneous transcatheter closure of a congenital ventricular septal defect with implant. Parcutaneous transcatheter closure of patent ductus arteriosus Gastric Electrical Stimulation and Gastric Pacing	93580 93581 93582 Codes	Prior authorization is required. Please refer to Per-Oral Endoscopic Myotomy, MP-DE-1226 for additional requirements. Prior Authorization Requirement Prior authorization is required. Please refer to Transcatheter Closure Devices for Septal Defects, MP-DE-1234 for additional requirements. Prior authorization is required. Please refer to Transcatheter Closure Devices for Septal Defects, MP-DE-1234 for additional requirements. Prior authorization is required. Please refer to Transcatheter Closure Devices for Septal Defects, MP-DE-1234 for additional requirements. Prior authorization is required. Please refer to Transcatheter Closure Devices for Septal Defects, MP-DE-1234 for additional requirements. Prior Authorization Requirement
Per-Oral Endoscopic Myotomy Unlisted procedure, esophagus Transcatheter Closure Devices for Septal Defects Percutaneous transcatheter closure of congenital interatrial communication (ie, Fortian fineastrain, artial septal defect with implant Percutaneous transcatheter closure of a congenital ventricular septal defect with implant Percutaneous transcatheter closure of patent ductus arteriosus Gastric Electrical Stimulation and Gastric Pacing Lapanoscopy, surgical; implantation or replacement of gastric neurostimulator electrodes, antum	43499 Codes 93580 93581 93582 Codes 43647	Prior authorization is required. Please refer to Per-Oral Endoscopic Myotomy, MP-DE-1226 for additional requirements. Prior Authorization Requirement Prior authorization is required. Please refer to Transcatheter Closure Devices for Septal Defects, MP-DE-1234 for additional requirements. Prior authorization is required. Please refer to Transcatheter Closure Devices for Septal Defects, MP-DE-1234 for additional requirements. Prior authorization is required. Please refer to Transcatheter Closure Devices for Septal Defects, MP-DE-1234 for additional requirements. Prior authorization is required. Please refer to Transcatheter Closure Devices for Septal Defects, MP-DE-1234 for additional requirements. Prior authorization Requirement Prior authorization is required. Please refer to Gastric Electrical Stimulation and Gastric Pacing, MP-DE-1235 for additional requirements.
Per-Oral Endoscopic Myotomy Unlisted procedure, esophagus Transcatheter Closure Devices for Septal Defects Percutaneous transcatheter closure of congenital interdiat communication (ie, Fontan fenestration, atrial septal defect) with implant Percutaneous transcatheter closure of a congenital ventricular septal defect with implant Percutaneous transcatheter closure of patent ductus arteriosus Gastric Electrical Stimulation and Gastric Pacing Laparoscopy, surgical; implantation or replacement of gastric neurostimulator	43499 Codes 93580 93581 93582 Codes 43647	Prior authorization is required. Please refer to Per-Oral Endoscopic Myotomy, MP-DE-1226 for additional requirements. Prior authorization Requirement Prior authorization is required. Please refer to Transcatheter Closure Devices for Septal Defects, MP-DE-1234 for additional requirements. Prior authorization is required. Please refer to Transcatheter Closure Devices for Septal Defects, MP-DE-1234 for additional requirements. Prior authorization is required. Please refer to Transcatheter Closure Devices for Septal Defects, MP-DE-1234 for additional requirements. Prior authorization requirements. Prior authorization Requirement Prior authorization is required. Please refer to Gastric Electrical Stimulation and Gastric Pacing, MP-DE-1235 for additional requirements. Prior authorization is required. Please refer to Gastric Electrical Stimulation and Gastric Pacing, MP-DE-1235 for additional requirements.
Per-Oral Endoscopic Myotomy Unlisted procedure, esophagus Transcatheter Closure Devices for Septal Defects Percutaneous transcatheter closure of congenital interdiat communication (ie, Fontan fenestration, atrial septal defect) with implant Percutaneous transcatheter closure of a congenital ventricular septal defect with implant Percutaneous transcatheter closure of patent ductus arteriosus Gastric Electrical Stimulation and Gastric Pacing Lapanscopy, surgical; implantation or replacement of gastric neurostimulator electrodes, antrum Lapanscopy, surgical; implantation or removal of	43499 Codes 93580 93581 93582 Codes 43647	Prior authorization is required. Please refer to Per-Oral Endoscopic Myotomy, MP-DE-1226 for additional requirements. Prior Authorization Requirement Prior authorization is required. Please refer to Transcatheter Closure Devices for Septal Defects, MP-DE-1234 for additional requirements. Prior authorization is required. Please refer to Transcatheter Closure Devices for Septal Defects, MP-DE-1234 for additional requirements. Prior authorization is required. Please refer to Transcatheter Closure Devices for Septal Defects, MP-DE-1234 for additional requirements. Prior authorization is required. Please refer to Transcatheter Closure Devices for Septal Defects, MP-DE-1234 for additional requirements. Prior authorization is required. Please refer to Gastric Electrical Stimulation and Gastric Pacing, MP-DE-1235 for additional requirements.
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Psychological testing evaluation services	96130	Please refer to Autism Spectrum Disorders, MP-DE-1045 for additional requirements.
by physicians or other qualified health		
care professional, including integration of patient data, interpretation or		
standardized test results and clinical		
data, clinical decision making, treatment		
planning and report, and interactive		
feedback to the patient, family		
member(s) or caregiver(s), when		
performed, first hour Psychological testing evaluation services	06121	Please refer to Autism Spectrum Disorders, MP-DE-1045 for additional requirements.
by physicians or other qualified health		
care professional, including integration		
of patient data, interpretation or		
standardized test results and clinical		
data, clinical decision making, treatment		
planning and report, and interactive feedback to the patient, family		
member(s) or caregiver(s), when		
performed, each additional hour (list		
separately in addition to code for primary		
procedure)	06422	Discounted Aution Contains Discolar AND DE 1045 for additional accidental
Neuropsychological testing evaluation services by physicians or other qualified	96132	Please refer to Autism Spectrum Disorders, MP-DE-1045 for additional requirements.
health care professional, including		
integration of patient data, interpretation		
or standardized test results and clinical		
data, clinical decision making, treatment		
planning and report, and interactive feedback to the patient, family		
member(s) or caregiver(s), when		
performed; first hour		
Neuropsychological testing evaluation	96133	Please refer to Autism Spectrum Disorders, MP-DE-1045 for additional requirements.
services by physicians or other qualified		
health care professional, including integration of patient data, interpretation		
or standardized test results and clinical		
data, clinical decision making, treatment		
planning and report, and interactive		
feedback to the patient, family		
member(s) or caregiver(s), when		
performed, each additional hour (list separately in addition to code for primary		
procedure)		
Psychological or neuropsychological test	96136	Please refer to Autism Spectrum Disorders, MP-DE-1045 for additional requirements.
administration and scoring by physicians		
or other qualified health care professional, two or more tests, any		
method; first 30 minutes		
Psychological or neuropsychological test	96137	Please refer to Autism Spectrum Disorders, MP-DE-1045 for additional requirements.
administration and scoring by physicians		
or other qualified health care		
professional, two or more tests, any		
method; each additional 30 minutes (list		
separately in addition to code for primary procedure)		
Psychological or neuropsychological test	96146	Please refer to Autism Spectrum Disorders, MP-DE-1045 for additional requirements.
administration, with single automated,	1	1
standardized instrument via electronic		
standardized instrument via electronic platform, with automated result only	Codes	Prior Authorization Requirement
standardized instrument via electronic platform, with automated result only Carpal Tunnel Surgery	Codes 79848	Prior Authorization Requirement Prior authorization is required, refer to Carnal Tunnel, MP-DF-1038 for additional requirements.
standardized instrument via electronic platform, with automated result only Carpal Tunnel Surgery Endoscopy, wrist, surgical, with release of transverse carpal ligament	29848	Prior authorization is required, refer to Carpal Tunnel, MP-DE-1038 for additional requirements.
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standardized instrument via electronic platform, with automated result only Carpal Tunnel Surgery Endoscopy, wrist, surgical, with release of transverse carpal ligament Neuroplasty and/or transposition; median nerve at carpal tunnel	29848 64721	Prior authorization is required, refer to Carpal Tunnel, MP-DE-1038 for additional requirements. Prior authorization is required, refer to Carpal Tunnel, MP-DE-1038 for additional requirements.
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Nasal/sinus endoscopy, surgical; with biopsy, polypectomy or debridement (separate procedure)	31237	Prior authorization is required. Please refer to Diagnosis and Treatment of Obstructive Sleep Apnea in Adults, MP-DE-1064 for additional requirements
Tracheostomy, planned (separate procedure);	31600	Prior authorization is required. Please refer to Diagnosis and Treatment of Obstructive Sleep Apnea in Adults, MP-DE-1064 for additional requirements
Glossectomy; less than one-half tongue	41120	Prior authorization is required. Please refer to Diagnosis and Treatment of Obstructive Sleep Apnea in Adults,
Glossectomy; hemiglossectomy	41130	MP-DE-1064 for additional requirements Prior authorization is required. Please refer to Diagnosis and Treatment of Obstructive Sleep Apnea in Adults,
Frenoplasty (surgical revision of frenum, eg,	41512	MP-DE-1064 for additional requirements Prior authorization is required. Please refer to Diagnosis and Treatment of Obstructive Sleep Apnea in Adults,
with Z-plasty) Submucosal ablation of the tongue base,	41530	MP-DE-1064 for additional requirements Prior authorization is required. Please refer to Diagnosis and Treatment of Obstructive Sleep Apnea in Adults,
radiofrequency, 1 or more sites, per session		MP-DE-1064 for additional requirements
Uvulectomy, excision of uvula	42140	Prior authorization is required. Please refer to Diagnosis and Treatment of Obstructive Sleep Apnea in Adults, MP-DE-1064 for additional requirements
Palatopharyngoplasty (eg, uvulopalatopharyngoplasty, uvulopharyngoplasty)	42145	Prior authorization is required. Please refer to Diagnosis and Treatment of Obstructive Sleep Apnea in Adults, MP-DE-1064 for additional requirements
Tonsillectomy and adenoidectomy; age 12 or	42821	Prior authorization is required. Please refer to Diagnosis and Treatment of Obstructive Sleep Apnea in Adults, MP-DE-1064 for additional requirements
Tonsillectomy, primary or secondary; age 12 or over	42826	Prior authorization is required. Please refer to Diagnosis and Treatment of Obstructive Sleep Apnea in Adults,
Adenoidectomy, primary; age 12 or over	42831	MP-DE-1064 for additional requirements Prior authorization is required. Please refer to Diagnosis and Treatment of Obstructive Sleep Apnea in Adults,
Adenoidectomy, secondary; younger than	42835	MP-DE-1064 for additional requirements Prior authorization is required. Please refer to Diagnosis and Treatment of Obstructive Sleep Apnea in Adults,
age 12 Adenoidectomy, secondary; age 12 or over	42836	MP-DE-1064 for additional requirements Prior authorization is required. Please refer to Diagnosis and Treatment of Obstructive Sleep Apnea in Adults,
Unlisted procedure, pharynx, adenoids, or	42999	MP-DE-1064 for additional requirements Prior authorization is required. Please refer to Diagnosis and Treatment of Obstructive Sleep Apnea in Adults,
tonsils		MP-DE-1064 for additional requirements
Unlisted procedure, palate, uvula	42299	Prior authorization is required. Please refer to Diagnosis and Treatment of Obstructive Sleep Apnea in Adults, MP-DE-1064 for additional requirements
Open implantation of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator	64568	Prior authorization is required. Please refer to Diagnosis and Treatment of Obstructive Sleep Apnea in Adults, MP-DE-1064 for additional requirements
Revision or replacement of cranial nerve (eg, vagus nerve) neurostimulator electrode array,	64569	Prior authorization is required. Please refer to Diagnosis and Treatment of Obstructive Sleep Apnea in Adults, MP-DE-1064 for additional requirements
including connection to existing pulse generator		INIT-DE-2004 IOI AGGILIONAL requirements
Removal of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator	64570	Prior authorization is required. Please refer to Diagnosis and Treatment of Obstructive Sleep Apnea in Adults, MP-DE-1064 for additional requirements
Insertion of implants into the soft palate; minimum of three implants	C9727	Prior authorization is required. Please refer to Diagnosis and Treatment of Obstructive Sleep Apnea in Adults, MP-DE-1064 for additional requirements
Diagnosis and Treatment of Obstructive	Codes	Prior Authorization Requirement
Sleep Apnea in Pediatric Individuals Multiple sleep latency or maintenance of	95805	Prior authorization is required. Please refer to Diagnosis and Treatment of Obstructive Sleep Apnea in
wakefulness testing, recording, analysis and interpretation of physiological measurements of sleep during multiple trials to assess sleepiness		Pediatric Individuals, MP-DE-1065 for additional requirements
Sleep study, unattended, simultaneous recording of, heart rate, oxygen saturation,	95806	Prior authorization is required. Please refer to Diagnosis and Treatment of Obstructive Sleep Apnea in Pediatric Individuals, MP-DE-1065 for additional requirements
respiratory airflow, and respiratory effort (eg, thoracoabdominal movement)		·
Sleep study, simultaneous recording of ventilation, respiratory effort, ECG or heart	95807	Prior authorization is required. Please refer to Diagnosis and Treatment of Obstructive Sleep Apnea in Pediatric Individuals, MP-DE-1065 for additional requirements
rate, and oxygen saturation, attended by a technologist	05000	
Polysomnography; any age, sleep staging with 1-3 additional parameters of sleep, attended by a technologist	95808	Prior authorization is required. Please refer to Diagnosis and Treatment of Obstructive Sleep Apnea in Pediatric Individuals, MP-DE-1065 for additional requirements
Polysomnography; age 6 years or older, sleep staging with 4 or more additional parameters of sleep, attended by a	95810	Prior authorization is required. Please refer to Diagnosis and Treatment of Obstructive Sleep Apnea in Pediatric Individuals, MP-DE-1065 for additional requirements
technologist Polysomnography; age 6 years or older,	95811	Prior authorization is required. Please refer to Diagnosis and Treatment of Obstructive Sleep Apnea in
sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bilevel ventilation, attended by a		Pediatric Individuals, MP-DE-1065 for additional requirements
technologist Circadian respiratory pattern recording	94772	Prior authorization is required. Please refer to Diagnosis and Treatment of Obstructive Sleep Apnea in
(pediatric pneumogram), 12-24 hour continuous recording, infant Polysomnography; younger than 6 years,	95782	Pediatric Individuals, MP-DE-1065 for additional requirements Prior authorization is required. Please refer to Diagnosis and Treatment of Obstructive Sleep Apnea in
sleep staging with 4 or more additional parameters of sleep, attended by a		Pediatric Individuals, MP-DE-1065 for additional requirements
technologist Polysomnography; younger than 6 years, sleep staging with 4 or more additional	95783	Prior authorization is required. Please refer to Diagnosis and Treatment of Obstructive Sleep Apnea in Pediatric Individuals, MP-DE-1065 for additional requirements
parameters of sleep, with initiation of continuous positive airway pressure therapy		rediatric individuals, ivir-05-1005 for additional requirements
or bi-level ventilation, attended by a technologist		
Continuous positive airway pressure (CPAP) device	E0601	Prior authorization is required when the billed charge is greater than \$500. Please refer to Diagnosis and Treatment of Obstructive Sleep Apnea in Pediatric Individuals, MP-DE-1065 for additional requirements
Apnea monitor, without recording feature	E0618	Prior authorization is required when the billed charge is greater than \$500. Please refer to Diagnosis and Treatment of Obstructive Sleep Apnea in Pediatric Individuals, MP-DE-1065 for additional requirements
Apnea monitor, with recording feature	E0619	Prior authorization is required when the billed charge is greater than \$500. Please refer to Diagnosis and Treatment of Obstructive Sleep Agnea in Pediatric Individuals, MP-DE-1065 for additional requirements
Oral device/appliance used to reduce upper airway collapsibility, adjustable or	E0485	Prior authorization is required when the billed charge is greater than \$500. Please refer to Diagnosis and
arrway collapsibility, adjustable or nonadjustable, prefabricated, includes fitting and adjustment		Treatment of Obstructive Sleep Apnea in Pediatric Individuals, MP-DE-1065 for additional requirements
Oral device/appliance used to reduce upper airway collapsibility, adjustable or	E0486	Prior authorization is required when the billed charge is greater than \$500. Please refer to Diagnosis and Treatment of Obstructive Sleep Apnea in Pediatric Individuals, MP-DE-1065 for additional requirements
nonadjustable, custom fabricated, includes fitting and adjustment		
	31600	Prior authorization is required. Please refer to Diagnosis and Treatment of Obstructive Sleep Apnea in Pediatric Individuals, MP-DE-1065 for additional requirements
Tracheostomy, planned (separate procedure); younger than 2 years	31601	Prior authorization is required. Please refer to Diagnosis and Treatment of Obstructive Sleep Apnea in Pediatric Individuals, MP-DE-1065 for additional requirements
Frenoplasty (surgical revision of frenum, eg, with Z-plasty)	41512	Prior authorization is required. Please refer to Diagnosis and Treatment of Obstructive Sleep Apnea in Pediatric Individuals, MP-DE-1065 for additional requirements
Submucosal ablation of the tongue base,	41530	Prior authorization is required. Please refer to Diagnosis and Treatment of Obstructive Sleep Apnea in
radiofrequency, 1 or more sites, per session Uvulectomy, excision of uvula	42140	Pediatric Individuals, MP-DE-1065 for additional requirements Prior authorization is required. Please refer to Diagnosis and Treatment of Obstructive Sleep Apnea in
Palatopharyngoplasty (eg,	42145	Pediatric Individuals, MP-DE-1065 for additional requirements Prior authorization is required. Please refer to Diagnosis and Treatment of Obstructive Sleep Apnea in
uvulopalatopharyngoplasty, uvulopharyngoplasty)		Pediatric Individuals, MP-DE-1065 for additional requirements
Tonsillectomy and adenoidectomy; younger than age 12	42820	Prior authorization is required. Please refer to Diagnosis and Treatment of Obstructive Sleep Apnea in Pediatric Individuals, MP-DE-1065 for additional requirements

Tonsillectomy and adenoidectomy; age 12 or over	42821	Prior authorization is required. Please refer to Diagnosis and Treatment of Obstructive Sleep Apnea in Pediatric Individuals, MP-DE-1065 for additional requirements
Tonsillectomy, primary or secondary; younger	42825	Prior authorization is required. Please refer to Diagnosis and Treatment of Obstructive Sleep Apnea in
than age 12		Pediatric Individuals, MP-DE-1065 for additional requirements
Tonsillectomy, primary or secondary; age 12 or over	42826	Prior authorization is required. Please refer to Diagnosis and Treatment of Obstructive Sleep Apnea in
Adenoidectomy, primary; younger than age	42830	Pediatric Individuals, MP-DE-1065 for additional requirements Prior authorization is required. Please refer to Diagnosis and Treatment of Obstructive Sleep Apnea in
12	42030	Pediatric Individuals, MP-DE-1065 for additional requirements
Adenoidectomy, primary; age 12 or over	42831	Prior authorization is required. Please refer to Diagnosis and Treatment of Obstructive Sleep Apnea in
		Pediatric Individuals, MP-DE-1065 for additional requirements
Adenoidectomy, secondary; younger than age 12	42835	Prior authorization is required. Please refer to Diagnosis and Treatment of Obstructive Sleep Apnea in Pediatric Individuals, MP-DE-1065 for additional requirements
Adenoidectomy, secondary; age 12 or over	42836	Prior authorization is required. Please refer to Diagnosis and Treatment of Obstructive Sleep Apnea in
1		Pediatric Individuals, MP-DE-1065 for additional requirements
Open implantation of cranial nerve (eg, vagus nerve) neurostimulator electrode array and	64568	Prior authorization is required. Please refer to Diagnosis and Treatment of Obstructive Sleep Apnea in
pulse generator		Pediatric Individuals, MP-DE-1065 for additional requirements
Revision or replacement of cranial nerve (eg,	64569	Prior authorization is required. Please refer to Diagnosis and Treatment of Obstructive Sleep Apnea in
vagus nerve) neurostimulator electrode array, including connection to existing pulse		Pediatric Individuals, MP-DE-1065 for additional requirements
generator		
Removal of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse	64670	Prior authorization is required. Please refer to Diagnosis and Treatment of Obstructive Sleep Apnea in Pediatric Individuals, MP-DE-1065 for additional requirements
generator		•
Polysomnography (PSG) for Non-	Codes	Prior Authorization Requirement
Respiratory Sleep Disorder Polysomnography; younger than 6 years,	95782	Prior authorization is required. Please refer to Polysomnography (PSG) for Non-Respiratory Sleep Disorder,
sleep staging with 4 or more additional	33702	MP-DE-1073 for additional requirements
parameters of sleep, attended by a technologist		
Polysomnography; younger than 6 years,	95783	Prior authorization is required. Please refer to Polysomnography (PSG) for Non-Respiratory Sleep Disorder,
sleep staging with 4 or more additional parameters of sleep, with initiation of		MP-DE-1073 for additional requirements
continuous positive airway pressure therapy		
or bi-level ventilation, attended by a technologist		
Multiple sleep latency or maintenance of	95805	Prior authorization is required. Please refer to Polysomnography (PSG) for Non-Respiratory Sleep Disorder,
wakefulness testing, recording, analysis and		MP-DE-1073 for additional requirements
interpretation of physiological measurements of sleep during multiple trials to assess		
sleepiness		
Polysomnography; any age, sleep staging with 1-3 additional parameters of sleep,	95808	Prior authorization is required. Please refer to Polysomnography (PSG) for Non-Respiratory Sleep Disorder, MP-DE-1073 for additional requirements
attended by a technologist		·
Polysomnography; age 6 years or older, sleep staging with 4 or more additional	95810	Prior authorization is required. Please refer to Polysomnography (PSG) for Non-Respiratory Sleep Disorder, MP-DE-1073 for additional requirements
parameters of sleep, attended by a		MP-DE-1073 for additional requirements
technologist Polysomnography; age 6 years or older,	95811	Prior authorization is required. Please refer to Polysomnography (PSG) for Non-Respiratory Sleep Disorder,
sleep staging with 4 or more additional	55011	MP-DE-1073 for additional requirements
parameters of sleep, with initiation of continuous positive airway pressure therapy		
or bilevel ventilation, attended by a		
technologist	lo. I.	
Private Duty Nursing Nursing care, in the home; by registered	Codes S9123	Prior Authorization Requirement Prior authorization is required. Please see Private Duty Nursing, MP-DE-1128 for additional requirements.
nurse, per hour		
Nursing care, in the home; by licensed practical nurse, per hour	S9124	Prior authorization is required. Please see Private Duty Nursing, MP-DE-1128 for additional requirements.
Respite care, in the home, per diem	59125	Prior authorization is required. Please see Private Duty Nursing, MP-DE-1128 for additional requirements.
Private duty/independent nursing service(s),	T1000	Prior authorization is required. Please see Private Duty Nursing, MP-DE-1128 for additional requirements.
licensed, up to 15 minutes Nursing assessment/evaluation	T1001	Prior authorization is required. Please see Private Duty Nursing, MP-DE-1128 for additional requirements.
RN services, up to 15 minutes	T1002	Prior authorization is required. Please see Private Duty Nursing, MP-DE-1128 for additional requirements.
Respite care services, up to 15 minutes	T1005	Prior authorization is required. Please see Private Duty Nursing, MP-DE-1128 for additional requirements.
Ambulatory Blood Pressure Monitors	Codes	Prior Authorization Requirement
Ambulatory blood pressure monitoring, utilizing report-generating software,	93784	Prior authorization is required. For additional information please reference Ambulatory Blood Pressure
automated, worn continuously for 24 hours or		Monitors, MP-DE-1032
longer; including recording, scanning analysis, interpretation and report		
Ambulatory blood pressure monitoring,	93786	Prior authorization is required. For additional information please reference Ambulatory Blood Pressure
utilizing report-generating software,		Monitors, MP-DE-1032
automated, worn continuously for 24 hours or longer; recording only		
Ambulatory blood pressure monitoring,	i	
	93788	Prior authorization is required. For additional information please reference Ambulatory Blood Pressure
utilizing report-generating software, automated, worn continuously for 24 hours or	93788	Prior authorization is required. For additional information please reference Ambulatory Blood Pressure Monitors, MP-DE-1032
automated, worn continuously for 24 hours or longer; scanning analysis with report		Monitors, MP-DE-1032
automated, worn continuously for 24 hours or	93788	Monitors, MP-DE-1032 Prior authorization is required. For additional information please reference Ambulatory Blood Pressure
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automated, worn continuously for 24 hours or longer; scanning analysis with report Arrbuistory blood pressure monitoring, utilizing report-generating software, automated, worn continuously for 24 hours or longer; review with interpretation and report Hyperbariac Oxygen Therapy Physician or other qualified health care professional attendance and supervision of hyperbariac oxygen therapy, per session Ectracorporeal iffe support (ECLS) provided by physician; initiation, veno-venous Extracorporeal membrane oxygenation (ECMO)extracorporeal iffe support (ECLS) provided by physician; initiation, veno-venous Extracorporeal membrane oxygenation (ECMO)extracorporeal iffe support (ECLS) provided by physician; initiation, veno-arterial Extracorporeal membrane oxygenation (ECMO)extracorporeal iffe support (ECLS) provided by physician; inality management, each day, veno-venous Extracorporeal membrane oxygenation (ECMO)extracorporeal iffe support (ECLS) provided by physician; inality management, each day, veno-arterial Extracorporeal membrane oxygenation (ECMO)extracorporeal iffe support (ECLS) provided by physician; inality management, each day, veno-arterial Extracorporeal membrane oxygenation (ECMO)extracorporeal iffe support (ECLS) provided by physician; insertion of peripheral (arterial and/or venous) cannula(e), percuraneous, birth through 5 years of age (includes fluoroscopic guidance, when performed)	93790 Codes 99183 Codes 33946 33947 33948 33949	Monitors, MP-DE-1032 Prior authorization is required. For additional information please reference Ambulatory Blood Pressure Monitors, MP-DE-1032 Prior Authorization Requirement Prior authorization is required. For additional information please reference Hyperbaraic Oxygen Therapy, MP-DE-1029 Prior Authorization Requirement Prior authorization is required. For additional information please reference Extracorporeal Membrane Oxygenation (ECMO), MP-DE-1061 Prior authorization is required. For additional information please reference Extracorporeal Membrane Oxygenation (ECMO), MP-DE-1061 Prior authorization is required. For additional information please reference Extracorporeal Membrane Oxygenation (ECMO), MP-DE-1061 Prior authorization is required. For additional information please reference Extracorporeal Membrane Oxygenation (ECMO), MP-DE-1061 Prior authorization is required. For additional information please reference Extracorporeal Membrane Oxygenation (ECMO), MP-DE-1061

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Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; insertion of peripheral (arterial and/or venous) cannula(e), open, 6	33954	Prior authorization is required. For additional information please reference Extracorporeal Membrane Oxygenation (ECMO), MP-DE-1061
years and older Extracorporeal membrane oxygenation	33955	Prior authorization is required. For additional information please reference Extracorporeal Membrane
(ECMO)/extracorporeal life support (ECLS) provided by physician; insertion of central cannula(e) by sternotomy or thoracotomy, birth through 5 years of age		Oxygenation (ECMO), MP-DE-1061
Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; insertion of central cannula(e) by sternotomy or thoracotomy, 6 years and older	33956	Prior authorization is required. For additional information please reference Extracorporeal Membrane Oxygenation (ECMO), MP-DE-1061
Extracorporeal membrane oxygenation (ECMO/pextracorporeal life support (ECLS) provided by physician; reposition peripheral (arterial and/or venous) cannulael, percutaneous, birth through 5 years of age (includes fluoroscopic guidance, when performed)	33957	Prior authorization is required. For additional information please reference Extracorporeal Membrane Oxygenation (ECMO), MP-DE-1061
Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; reposition peripheral (arterial and/or venous) cannula(e), percutaneous, 6 years and older (includes	33958	Prior authorization is required. For additional information please reference Extracorporeal Membrane Oxygenation (ECMO), MP-DE-1061
fluoroscopic guidance, when performed) Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; reposition peripheral (arterial and/or venous) cannula(e), open, birth through 5 years of age (includes	33959	Prior authorization is required. For additional information please reference Extracorporeal Membrane Oxygenation (ECMO), MP-DE-1061
fluoroscopic guidance, when performed) Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; reposition peripheral (arterial and/or venous) cannula(e), open, 6 years and older (includes fluoroscopic guidance, when performed)	33962	Prior authorization is required. For additional information please reference Extracorporeal Membrane Oxygenation (ECMO), MP-DE-1061
guidance, when pernormad) Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) rovided by physician; reposition of central cannula(e) by sternotomy or thoracotomy, birth through 5 years of age (includes fluoroscopic guidance, when performed)	33963	Prior authorization is required. For additional information please reference Extracorporeal Membrane Oxygenation (ECMO), MP-DE-1061
Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; reposition central cannula(e) by sternotomy or thoracotomy, 6 years and older (includes fluoroscopic guidance, when performed)	33964	Prior authorization is required. For additional information please reference Extracorporeal Membrane Oxygenation (ECMO), MP-DE-1061
Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; removal of peripheral (arterial and/or venous) cannula(e), percutaneous, birth through 5 years of age Extracorporeal membrane oxygenation	33965	Prior authorization is required. For additional information please reference Extracorporeal Membrane Oxygenation (ECMO), MP-DE-1061
(ECMO)/extracorporeal life support (ECLS) provided by physician; removal of peripheral (arterial and/or venous) cannula(e), percutaneous, 6 years and older	33966	Prior authorization is required. For additional information please reference Extracorporeal Membrane Oxygenation (ECMO), MP-DE-1061
Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; removal of peripheral (arterial and/or venous) cannula(e), open, birth through 5 years of age	33969	Prior authorization is required. For additional information please reference Extracorporeal Membrane Oxygenation (ECMO), MP-DE-1061
Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; removal of peripheral (arterial and/or venous) cannula(e), open, 6 years and older	33984	Prior authorization is required. For additional information please reference Extracorporeal Membrane Oxygenation (ECMO), MP-DE-1061
Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; removal of central cannula(e) by sternotomy or thoracotomy, birth through 5 years of age	33985	Prior authorization is required. For additional information please reference Extracorporeal Membrane Oxygenation (ECMO), MP-DE-1061
Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; removal of central cannula(e) by sternotomy or thoracotomy, 6 years and older	33986	Prior authorization is required. For additional information please reference Extracorporeal Membrane Oxygenation (ECMO), MP-DE-1061
Arterial exposure with creation of graft conduit (eg. chimney graft) to facilitate arterial perfusion for ECMO/ECLS (List separately in addition to code for primary procedure)	33987	Prior authorization is required. For additional information please reference Extracorporeal Membrane Oxygenation (ECMO), MP-DE-1061
Insertion of left heart vent by thoracic incision (eg, sternotomy, thoracotomy) for ECMO/ECLS Removal of left heart vent by thoracic	33988 33989	Prior authorization is required. For additional information please reference Extracorporeal Membrane Oxygenation (ECMO), MP-DE-1061 Prior authorization is required. For additional information please reference Extracorporeal Membrane
incision (eg, sternotomy, thoracotomy) for ECMO/ECLS Wireless Capsule Endoscopy as a Diagnostic Technique in Disorders of the	Codes	Oxygenation (ECMO), MP-DE-1061 Prior Authorization Requirement
Small Bowel, Esophagus, and Colon Gastrointestinal tract imaging, intraluminal (eg. capsule endoscopy), esophagus through	91110	Prior authorization is required. For additional information please reference Wireless Capsule Endoscopy as a Diagnostic Technique in Disorders of the Small Bowel, Esophagus, and Colon, MP-DE-1005.
ileum, with interpretation and report Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus with interpretation and report	91111	Prior authorization is required. For additional information please reference Wireless Capsule Endoscopy as a Diagnostic Technique in Disorders of the Small Bowel, Esophagus, and Colon, MP-DE-1005.
Gastrointestinal tract imaging, intraluminal (eg. capsule endoscopy), colon, with interpretation and report Unlisted diagnostic gastroenterology	91113 91299	Prior authorization is required. For additional information please reference Wireless Capsule Endoscopy as a Diagnostic Technique in Disorders of the Small Bowel, Esophagus, and Colon, MP-DE-1005. Prior authorization is required. For additional information please reference Wireless Capsule Endoscopy as a
Donor Leukocyte Infusion for Hematologic Malignancies that Relapse	91299 Codes	Prior authorization is required. For additional information please reference Wireless Capsule Endoscopy as a Diagnostic Technique in Disorders of the Small Bowel, Esophagus, and Colon, MP-DE-1005. Prior Authorization Requirement
Hematologic Malignancies that Relapse after Allogeneic Cell Transplantation Therapeutic apheresis; for white blood cells	36511	Prior authorization is required. For additional information please reference Donor Leukocyte Infusion for
Allogeneic lymphocyte infusions	38242	Hematologic Malignancies that Relapse after Allogeneic Cell Transplantation, MP-DE-1019 Prior authorization is required for additional information please reference Donor Leukocyte Infusion for Hematologic Malignancies that Relapse after Allogeneic Cell Transplantation, MP-DE-1019
Islet Cell Transplantation	Codes	Prior Authorization Requirement
Pancreatectomy, total or subtotal, with autologous transplantation of pancreas or pancreatic islet cells	48160	Prior authorization is required. For additional information please reference Islet Cell Transplantation , MP-DE- 1021 Prior Authorization Paguirement
Transcather Pulmonary Valve Implantation	Codes	Prior Authorization Requirement

Transcatheter pulmonary valve implantation, percutaneous approach, including pre- stenting of the valve delivery site, when performed	33477	Prior authorization is required. For additional information please reference Transcatheter Pulmonary Valve Implantation, MP-DE-1022
Magnetic Esophageal Ring to Treat Gastroesophageal Reflux Disease (LINX)	Codes	Prior Authorization Requirement
Laparoscopy, surgical, esophageal sphincter augmentation procedure, placement of sphincter augmentation device (ie, magnetic band), including cruroplasty when performed	43284	Prior authorization is required. For additional information please reference Magnetic Esophageal Ring to Treat Gastroesophageal Reflux Disease (LINX), MP-DE-1023
Removal of esophageal sphincter	43285	Prior authorization is required. For additional information please reference Magnetic Esophageal Ring to
augmentation device Unlisted laparoscopy procedure, esophagus	43289	Treat Gastroesophageal Reflux Disease (LINX), MP-DE-1023 Prior authorization is required. For additional information please reference Magnetic Esophageal Ring to
Treatment of Malignant Skin Lesions	Codes	Treat Gastroesophageal Reflux Disease (LINX), MP-DE-1023 Prior Authorization Requirement
Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, incrinoscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), head, neck, hands, feet, genitalia, or any location with surgeny directly involving muscle, cartilage, bone, tendon, major narves, or vessels; first stage, up to 5 tissue blocks	17311	Prior authorization is required. For additional information please reference Treatment of Malignant Skin Lesions, MP-DE-1034
Mohs micrographic technique, including removal of all gross tumor, surgical excision of issues specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine staris(s) (eg., heraboxylin and dosin, foliudine blue), head, neck, hands, feet, genitalia, or any location with surgery directly involving muscle, cartilage, bone, tendon, major nerves, or vessels; each additional stage after the first stage, up to 5 tissue blocks (List separately in addition to code for primary procedure)	17312	Prior authorization is required. For additional information please reference Treatment of Malignant Skin Lesions, MP-DE-1034
Moha microgaphic technique, including removal of all gross tumor, surgical excision of issues specimens, mapping, color oxing of specimens, microscopic examination of specimens by the surgoen, and histopathologic preparation including routine statin(s) (eg., herantoxylin and eosin, toludine blue), of the trunk, arms, or legs; first stage, up to 5 tissue blocks	17313	Prior authorization is required. For additional information please reference Treatment of Malignant Skin Lesions, MP-DE-1034
Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, incrinoscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (e), hematoxylin and eosin, toluidine blue), of the trunk, arms, or legs; each additional stage after the first stage, up to 5 tissue blocks (List separately in addition to code for primary procedure)	17314	Prior authorization is required. For additional information please reference Treatment of Malignant Skin Lesions, MP-DE-1034
Mohas micrographic technique, including removal of all gross turnor, surgical excision of tissue specimens, mapping, color coding of specimens, incrinocacpic examination of specimens by the surgeon, and histopathologic preparation including routine statia(s) (e), hematoxylin and eosin, toluidine blue), each additional block after the first 5 tissue blocks, any stage (List separately in addition to code for primary procedure)	17315	Prior authorization is required. For additional information please reference Treatment of Malignant Skin Lesions, MP-DE-1034
Pathology consultation during surgery; first tissue block, with frozen section(s), single specimen	88331	Prior authorization is required. For additional information please reference Treatment of Malignant Skin Lesions, MP-DE-1034
Pathology consultation during surgery; each additional tissue block with frozen section(s) (List separately in addition to code for primary procedure)	88332	Prior authorization is required. For additional information please reference Treatment of Malignant Skin Lesions, MP-DE-1034
Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), initial site	88333	Prior authorization is required. For additional information please reference Treatment of Malignant Skin Lesions, MP-DE-1034
Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), each additional site (List separately in addition to code for primary procedure)	83334	Prior authorization is required. For additional information please reference Treatment of Malignant Skin Lesions, MP-DE-1034
Photodynamic therapy by external application of light to destroy premalignant lesions of the skin and adjacent mucosa with application and illumination/activation of photosensitive drug(s), per day		Prior authorization is required. For additional information please reference Treatment of Malignant Skin Lesions, MP-DE-1034
Photodynamic therapy by external application of light to destroy premalignant lesions of the skin and adjacent mucosa with application and illumination/activation of photosensitizing drug(s) provided by a physician or other qualified health care professional, per day	96573	Prior authorization is required. For additional information please reference Treatment of Malignant Skin Lesions, MP-DE-1034
Debridement of premalignant hyperkeratotic lesion(s) (ei, largeded curettage, abrasion) followed with photodynamic therapy by external application of light to destroy premalignant lesions of the sixin and algicent mucosa with application and middle and mucosa with application and largeded interest and adjusted for the provision of photosensitizing drug(s) provided by a physician or other qualified health care professional, per day	96574	Prior authorization is required. For additional information please reference Treatment of Malignant Skin Lesions, MP-DE-1034
Artificial Hearts and Ventricular Assist Devices	Codes	Prior Authorization Requirement
Implantation of a total replacement heart system (artificial heart) with recipient	33927	Prior authorization is required. For additional information please reference Artificial Hearts and Ventricular Assist Devices, MP-DE-1104
cardiectomy Removal and replacement of total replacement heart system (artificial heart)	33928	Prior authorization is required. For additional information please reference Artificial Hearts and Ventricular Assist Devices, MP-DE-1104
Removal of a total replacement heart system (artificial heart) for heart transplantation (List separately in addition to code for primary	33929	Assist Devices, in: Prior authorization is required. For additional information please reference Artificial Hearts and Ventricular Assist Devices, MP-DE-1104
procedure) Insertion of ventricular assist device;	33975	Prior authorization is required. For additional information please reference Artificial Hearts and Ventricular
extracorporeal, single ventricle		Assist Devices, MP-DE-1104

Insertion of ventricular assist device; extracorporeal, biventricular	33976	Prior authorization is required. For additional information please reference Artificial Hearts and Ventricular Assist Devices, MP-DE-1104
Removal of ventricular assist device;	33977	Prior authorization is required. For additional information please reference Artificial Hearts and Ventricular
extracorporeal, single ventricle Removal of ventricular assist device:	33978	Assist Devices, MP-DE-1104 Prior authorization is required. For additional information please reference Artificial Hearts and Ventricular
extracorporeal, biventricular	33776	Assist Devices, MP-DE-1104
Insertion of ventricular assist device, implantable intracorporeal, single ventricle	33979	Prior authorization is required. For additional information please reference Artificial Hearts and Ventricular Assist Devices. MP-DE-1104
Removal of ventricular assist device,	33980	Prior authorization is required. For additional information please reference Artificial Hearts and Ventricular
implantable intracorporeal, single ventricle Replacement of extracorporeal ventricular	33981	Assist Devices, MP-DE-1104 Prior authorization is required. For additional information please reference Artificial Hearts and Ventricular
assist device, single or biventricular,	33761	Assist Devices, MP-DE-1104
pump(s), single or each pump Replacement of ventricular assist device	33982	Prior authorization is required. For additional information please reference Artificial Hearts and Ventricular
pump(s); implantable intracorporeal, single ventricle, without cardiopulmonary bypass		Assist Devices, MP-DE-1104
Replacement of ventricular assist device pump(s); implantable intracorporeal, single	33983	Prior authorization is required. For additional information please reference Artificial Hearts and Ventricular Assist Devices, MP-DE-1104
ventricle, with cardiopulmonary bypass Insertion of ventricular assist device,	33990	Prior authorization is required. For additional information please reference Artificial Hearts and Ventricular
percutaneous, including radiological supervision and interpretation; left heart.	33330	Assist Devices, MP-DE-1104
arterial access only		
Insertion of ventricular assist device, percutaneous, including radiological	33991	Prior authorization is required. For additional information please reference Artificial Hearts and Ventricular Assist Devices, MP-DE-1104
supervision and interpretation; left heart, both arterial and venous access, with transseptal		
puncture Removal of percutaneous left heart	33992	Prior authorization is required. For additional information please reference Artificial Hearts and Ventricular
ventricular assist device, arterial or arterial and venous cannula(s), at separate and	33372	Assist Devices, MP-DE-1104
distinct session from insertion		
Repositioning of percutaneous right or left heart ventricular assist device with imaging	33993	Prior authorization is required. For additional information please reference Artificial Hearts and Ventricular Assist Devices, MP-DE-1104
guidance at separate and distinct session from insertion		
Insertion of ventricular assist device, percutaneous, including radiological	33995	Prior authorization is required. For additional information please reference Artificial Hearts and Ventricular
supervision and interpretation; right heart,		Assist Devices, MP-DE-1104
venous access only Removal of percutaneous right heart	33997	Prior authorization is required. For additional information please reference Artificial Hearts and Ventricular
ventricular assist device, venous cannula, at separate and distinct session from insertion		Assist Devices, MP-DE-1104
Unlisted procedure, cardiac surgery	33999	Prior authorization is required. For additional information please reference Artificial Hearts and Ventricular
		Assist Devices, MP-DE-1104
Interrogation of ventricular assist device (VAD), in person, with physician or other	93750	Prior authorization is required. For additional information please reference Artificial Hearts and Ventricular Assist Devices, MP-DE-1104
qualified health care professional analysis of device parameters (eg, drivelines, alarms,		ASSIST DEVICES, WILL DE TENT
power surges), review of device function (eg, flow and volume status, septum status,		
recovery), with programming, if performed,		
and report Miscellaneous component, supply or	L8698	Prior authorization is required for billed charges greater than \$500. For additional information please
accessory for use with total artificial heart system		reference Artificial Hearts and Ventricular Assist Devices, MP-DE-1104
Cardina Dahah		
Cardiac Rehab	Codes	Prior Authorization Requirement
Physician or other qualified health care professional services for outpatient cardiac	93798	Prior Authorization Requirement Prior authorization is required. For additional information please reference Cardiac Rehab, MP-DE-1026
Physician or other qualified health care professional services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session)		
Physician or other qualified health care professional services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session) Treatment of Twin-Twin Transfusion		
Physician or other qualified health care professional services for outpatient cardiac rehabilitation, with continuous ECG monitoring (per session) Treatment of Twin-Twin Transfusion Syndrome with Amnioreductionand/or Fetoscopic Laser Therapy	93798	Prior authorization is required. For additional information please reference Cardiac Rehab, MP-DE-1026
Physician or other qualified health care professional services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session) Treatment of Twin-Twin Transfusion Syndrome with Amnioreductionand/or	93798	Prior authorization is required. For additional information please reference Cardiac Rehab, MP-DE-1026 Prior Authorization Requirement Prior authorization is required. For additional information please reference Treatment of Twin-Twin
Physician or other qualified health care professional services for outpatient cardiac enhabilitation: with continuous ECG monitoring (per session). Treatment of Twin-Twin Transfusion Syndrome with Amnioreductionand/or Fetoscopic Laser Therapy Unlisted diagnostic radiographic procedure. Unlisted ultrasound procedure (eg.	93798 Codes	Prior authorization is required. For additional information please reference Cardiac Rehab, MP-DE-1026 Prior Authorization Requirement Prior authorization is required. For additional information please reference Treatment of Twin-Twin Transfusion Syndrome with Amnioreductionand/or Fetoscopic Laser Therapy, MP-DE-1043 Prior authorization is required. For additional information please reference Treatment of Twin-Twin
Physician or other qualified health care professional services for outpatient cardiac rehabilitation, with continuous ECG monitoring per session) Treatment of Twin-Twin Transfusion Syndrome with Amnioreductionand/or Fetoscopic Laser Therapy Unitsted diagnostic radiographic procedure Unlisted ultrasound procedure (eg. diagnostic, interventional)	93798 Codes 76499	Prior authorization is required. For additional information please reference Cardiac Rehab, MP-DE-1026 Prior Authorization Requirement Prior authorization is required. For additional information please reference Treatment of Twin-Twin Transfusion Syndrome with Amnioreductionand/or Fetoscopic Laser Therapy, MP-DE-1043 Prior authorization is required. For additional information please reference Treatment of Twin-Twin Transfusion Syndrome with Amnioreductionand/or Fetoscopic Laser Therapy, MP-DE-1043
Enysician or other qualified health care professional services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session) Treatment of Twin-Twin Transfusion Syndrome with Amnioreductionand/or Fetoscopic Laser Therapy Unlisted diagnostic radiographic procedure Unlisted ultrasound procedure (eg. diagnostic, interventional) Armiocentesis; therapeutic ammiotic fluid reduction (includes ultrasound guidance)	93798 Codes 76499	Prior authorization is required. For additional information please reference Cardiac Rehab, MP-DE-1026 Prior Authorization Requirement Prior authorization is required. For additional information please reference Treatment of Twin-Twin Transfusion Syndrome with Amnioreductionand/or Fetoscopic Laser Therapy, MP-DE-1043 Prior authorization is required. For additional information please reference Treatment of Twin-Twin Transfusion Syndrome with Amnioreductionand/or Fetoscopic Laser Therapy, MP-DE-1043 Prior authorization is required. For additional information please reference Treatment of Twin-Twin Transfusion Syndrome with Amnioreductionand/or Fetoscopic Laser Therapy, MP-DE-1043
Physician or other qualified health care professional services for outpatient cardiac rehabilitation, with continuous ECG monitoring per session) Treatment of Twin-Twin Transfusion Syndrome with Amnioreductionand/or Fetoscopic Laser Therapy Unisted diagnostic radiographic procedure Unlisted ultrasound procedure (eg. diagnostic, interventional) Armiocentesis; therapeutic armiotic fluid reduction (includes ultrasound guidance) Recombinant and Autologous Platelet-	93798 Codes 76499	Prior authorization is required. For additional information please reference Cardiac Rehab, MP-DE-1026 Prior Authorization Requirement Prior authorization is required. For additional information please reference Treatment of Twin-Twin Transfusion Syndrome with Amnioreductionand/or Fetoscopic Laser Therapy, MP-DE-1043 Prior authorization is required. For additional information please reference Treatment of Twin-Twin Transfusion Syndrome with Amnioreductionand/or Fetoscopic Laser Therapy, MP-DE-1043 Prior authorization is required. For additional information please reference Treatment of Twin-Twin Transfusion Syndrome with Amnioreductionand/or Fetoscopic Laser Therapy, MP-DE-1043 Prior authorization is required. For additional information please reference Treatment of Twin-Twin
Enysician or other qualified health care professional services for outpatient cardiac rehabilitation; with continuous ECG monitoring per session) Treatment of Twin-Twin Transfusion Syndrome with Amnioreductionand/or Fetoscopic Laser Therapy Unlisted diagnostic radiographic procedure Unlisted ultrasound procedure (eg. diagnostic, interventional) Armiocentesis; therapeutic amniotic fluid reduction (includes ultrasound guidance) Recombinant and Autologous Platelet- Derived Growth Factors for Wound Healing and Other Non-Orthopedic	93798 Codes 76499 76999 59001	Prior authorization is required. For additional information please reference Cardiac Rehab, MP-DE-1026 Prior Authorization Requirement Prior authorization is required. For additional information please reference Treatment of Twin-Twin Transfusion Syndrome with Amnioreductionand/or Fetoscopic Laser Therapy, MP-DE-1043 Prior authorization is required. For additional information please reference Treatment of Twin-Twin Transfusion Syndrome with Amnioreductionand/or Fetoscopic Laser Therapy, MP-DE-1043 Prior authorization is required. For additional information please reference Treatment of Twin-Twin Transfusion Syndrome with Amnioreductionand/or Fetoscopic Laser Therapy, MP-DE-1043
Enjusician or other qualified health care professional services for outpatient cardiac rehabilitation: with continuous ECG monitoring (per seasion) Treatment of Twin-Twin Irransfusion Syndrome with Amnioreductionand/or Fetoscopic Laser Therapy Unilsted diagnostic radiographic procedure Unilsted diagnostic interventional) Armiocentesis; therapeutic armiotic fluid reduction (includes ultrasound guidance) Recombinant and Autologous Platelet- Derived Growth Factors for Wound Healing and Other Non-Orthopedic Conditions	93798 Codes 76499 76999 59001 Codes	Prior authorization is required. For additional information please reference Cardiac Rehab, MP-DE-1026 Prior Authorization Requirement Prior authorization is required. For additional information please reference Treatment of Twin-Twin Transfusion Syndrome with Amnioreductionand/or Fetoscopic Laser Therapy, MP-DE-1043 Prior authorization is required. For additional information please reference Treatment of Twin-Twin Transfusion Syndrome with Amnioreductionand/or Fetoscopic Laser Therapy, MP-DE-1043 Prior authorization is required. For additional information please reference Treatment of Twin-Twin Transfusion Syndrome with Amnioreductionand/or Fetoscopic Laser Therapy, MP-DE-1043 Prior Authorization Requirement
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Bone marrow harvesting for transplantation; autologous	38232	Prior authorization is required. For additional information please reference Hematopoietic Cell Transplantation (HCT) for Autoimmune Diseases, MP-DE-1103
Hematopoietic progenitor cell (HPC);	38241	Prior authorization is required. For additional information please reference Hematopoietic Cell
autologous transplantation Bone marrow harvesting for transplantation;	38230	Transplantation (HCT) for Autoimmune Diseases, MP-DE-1103 Prior authorization is required. For additional information please reference Hematopoietic Cell
allogeneic	38230	Transplantation (HCT) for Autoimmune Diseases, MP-DE-1103
Hematopoietic progenitor cell (HPC); allogeneic transplantation per donor	38240	Prior authorization is required. For additional information please reference Hematopoietic Cell
Hematopoietic Cell Transplantation for	Codes	Transplantation (HCT) for Autoimmune Diseases, MP-DE-1103 Prior Authorization Requirement
CNS Embryonal Tumors and Ependymoma		·
Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; autologous	38206	Prior authorization is required. For additional information please reference Hematopoietic Cell Transplantation for CNS Embryonal Tumors and Ependymoma, MP-DE-1107
Bone marrow harvesting for transplantation; autologous	38232	Prior authorization is required. For additional information please reference Hematopoietic Cell Transplantation for CNS Embryonal Tumors and Ependymoma, MP-DE-1107
Hematopoietic progenitor cell (HPC);	38240	Prior authorization is required. For additional information please reference Hematopoietic Cell
allogeneic transplantation per donor Hematopoietic progenitor cell (HPC):	38241	Transplantation for CNS Embryonal Tumors and Ependymoma, MP-DE-1107 Prior authorization is required. For additional information please reference Hematopoietic Cell
autologous transplantation		Transplantation for CNS Embryonal Tumors and Ependymoma, MP-DE-1107
Bone marrow harvesting for transplantation; allogeneic	38230	Prior authorization is required. For additional information please reference Hematopoietic Cell Transplantation for CNS Embryonal Tumors and Ependymoma, MP-DE-1107
Hematopoietic Cell Transplantation from	Codes	Prior Authorization Requirement
Chronic Myeloid Leukemia Bone marrow harvesting for transplantation;	38230	Prior authorization is required. For additional information please reference Hematopoietic Cell
allogeneic		Transplantation from Chronic Myeloid Leukemia, MP-DE-1113
Hematopoietic progenitor cell (HPC); allogeneic transplantation per donor	38240	Prior authorization is required. For additional information please reference Hematopoietic Cell Transplantation from Chronic Myeloid Leukemia, MP-DE-1113
Hematopoietic progenitor cell (HPC);	38241	Prior authorization is required. For additional information please reference Hematopoietic Cell
autologous transplantation Hematopoietic Cell Transplantation for	Codes	Transplantation from Chronic Myeloid Leukemia, MP-DE-1113 Prior Authorization Requirement
Solid Tumors of Childhood Surgery		·
Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection;	38206	Prior authorization is required. For additional information please reference Hematopoietic Cell Transplantation for Solid Tumors of Childhood Surgery, MP-DE-1118
autologous Bone marrow harvesting for transplantation; allogeneic	38230	Prior authorization is required. For additional information please reference Hematopoietic Cell
allogeneic Bone marrow harvesting for transplantation;	38232	Transplantation for Solid Tumors of Childhood Surgery, MP-DE-1118 Prior authorization is required. For additional information please reference Hematopoietic Cell
autologous		Transplantation for Solid Tumors of Childhood Surgery, MP-DE-1118
Hematopoietic progenitor cell (HPC); allogeneic transplantation per donor	38240	Prior authorization is required. For additional information please reference Hematopoietic Cell Transplantation for Solid Tumors of Childhood Surgery, MP-DE-1118
Hematopoietic progenitor cell (HPC);	38241	Prior authorization is required. For additional information please reference Hematopoietic Cell
Allogeneic lymphocyte infusions	38242	Transplantation for Solid Tumors of Childhood Surgery, MP-DE-1118 Prior authorization is required. For additional information please reference Hematopoietic Cell
		Transplantation for Solid Tumors of Childhood Surgery, MP-DE-1118
Hematopoietic Cell Transplantation in Treatment of Germ-Cell Tumors	Codes	Prior Authorization Requirement
Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection;	38206	Prior authorization is required. For additional information please reference Hematopoietic Cell
autologous Hematopoietic progenitor cell (HPC);	38240	Transplantation in Treatment of Germ-Cell Tumors, MP-DE-1119 Prior authorization is required. For additional information please reference Hematopoietic Cell
allogeneic transplantation per donor		Transplantation in Treatment of Germ-Cell Tumors, MP-DE-1119
Hematopoietic progenitor cell (HPC); autologous transplantation	38241	Prior authorization is required. For additional information please reference Hematopoietic Cell Transplantation in Treatment of Germ-Cell Tumors, MP-DE-1119
Hematopoietic Cell Transplantation in	Codes	Prior Authorization Requirement
Waldenstrom Macroglobulinemia Blood-derived hematopoietic progenitor cell	38206	Prior authorization is required. For additional information please reference Hematopoietic Cell
harvesting for transplantation, per collection; autologous	35255	Transplantation in Waldenstrom Macroglobulinemia, MP-DE-1121
Bone marrow harvesting for transplantation;	38230	Prior authorization is required. For additional information please reference Hematopoietic Cell
allogeneic Bone marrow harvesting for transplantation;	38232	Transplantation in Waldenstrom Macroglobulinemia, MP-DE-1121 Prior authorization is required. For additional information please reference Hematopoietic Cell
autologous		Transplantation in Waldenstrom Macroglobulinemia, MP-DE-1121
Hematopoietic progenitor cell (HPC); allogeneic transplantation per donor	38240	Prior authorization is required. For additional information please reference Hematopoietic Cell Transplantation in Waldenstrom Macroglobulinemia, MP-DE-1121
Hematopoietic progenitor cell (HPC);	38241	Prior authorization is required. For additional information please reference Hematopoietic Cell
autologous transplantation Orthopedic Applications of Stem-Cell	Codes	Transplantation in Waldenstrom Macroglobulinemia, MP-DE-1121 Prior Authorization Requirement
Therapy		·
Allograft, includes templating, cutting, placement and internal fixation, when	20932	Prior authorization is required. For additional information please reference Orthopedic Applications of Stem- Cell Therapy, MP-DE-1122
performed; osteoarticular, including articular surface and contiguous bone (List separately		· "
in addition to code for primary procedure)		
Allograft, includes templating, cutting, placement and internal fixation, when	20933	Prior authorization is required. For additional information please reference Orthopedic Applications of Stem-
performed; hemicortical intercalary, partial (ie,		Cell Therapy, MP-DE-1122
hemicylindrical) (List separately in addition to code for primary procedure)		
Allograft, includes templating, cutting, placement and internal fixation, when	20934	Prior authorization is required. For additional information please reference Orthopedic Applications of Stem- Cell Therapy, MP-DE-1122
performed; intercalary, complete (ie, cylindrical) (List separately in addition to		· "
code for primary procedure) Blood-derived hematopoietic progenitor cell	38206	Prior authorization is required. For additional information please reference Orthopedic Applications of Stem-
harvesting for transplantation, per collection; autologous	55255	Cell Therapy, MP-DE-1122
Bone marrow harvesting for transplantation; allogeneic	38230	Prior authorization is required. For additional information please reference Orthopedic Applications of Stem-
Bone marrow harvesting for transplantation;	38232	Cell Therapy, MP-DE-1122 Prior authorization is required. For additional information please reference Orthopedic Applications of Stem-
autologous		Cell Therapy, MP-DE-1122
Hematopoietic progenitor cell (HPC); autologous transplantation	38241	Prior authorization is required. For additional information please reference Orthopedic Applications of Stem- Cell Therapy, MP-DE-1122
Esophageal Ph Monitoring	Codes	Prior Authorization Requirement
Esophagus, gastroesophageal reflux test; with nasal catheter pH electrode(s)	91034	Prior authorization is required. For additional information please reference Esophageal Ph Monitoring, MP- DE-1087
	I	
placement, recording, analysis and interpretation		
interpretation Esophagus, gastroesophageal reflux test;	91035	Prior authorization is required. For additional information please reference Esophageal Ph Monitoring, MP-
interpretation Esophagus, gastroesophageal reflux test; with mucosal attached telemetry pH electrode placement, recording, analysis and	91035	Prior authorization is required. For additional information please reference Esophageal Ph Monitoring, MP- DE-1087
Interpretation Esophagus, gastroesophageal reflux test; with mucosal attached telemetry pH electrode placement, recording, analysis and interpretation Electroencephalogram (EEG)	91035 Codes	
Interpretation Esophagus, gastroesophageal reflux test; with mucosal attached telemetry pH electrode placement, recording, analysis and interpretation Electroencephalogram (EEG) Technologies Electroencephalogram (EEG) continuous		DE-1087
interpretation Es ophagus, gastroesophageal reflux test; with mucosal attached telemetry pH electrode placement, recording, analysis and interpretation Electroencephalogram (EEG) Technologies Electroencephalogram (EEG) continuous recording, with video when performed, setup, patient education, and takedown when	Codes	DE-1087 Prior Authorization Requirement
interpretation Escophagus, gastroesophageai reflux test; with muscal attached telemetry pH electrode placement, recording, analysis and interpretation Electroencephalogram (EEG) Technologies Electroencephalogram (EEG) continuous recording, with video when performed, setup,	Codes	DE-1087 Prior Authorization Requirement Prior authorization is required. For additional information please reference Electroencephalogram (EEG)

Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, 2-12 hours; unmonitored	95705	Prior authorization is required. For additional information please reference Electroencephalogram (EEG) Technologies, MP-DE-1088
Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, 2-12 hours; with intermittent	95706	Prior authorization is required. For additional information please reference Electroencephalogram (EEG) Technologies, MP-DE-1088
monitoring and maintenance Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, 2-12 hours; with continuous, real-time monitoring and maintenance	95707	Prior authorization is required. For additional information please reference Electroencephalogram (EEG) Technologies, MP-DE-1088
Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, each increment of 12-26 hours;	95708	Prior authorization is required. For additional information please reference Electroencephalogram (EEG) Technologies, MP-DE-1088
unmonitored Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, each increment of 12-26 hours; with intermittent monitoring and maintenance	95709	Prior authorization is required. For additional information please reference Electroencephalogram (EEG) Technologies, MP-DE-1088
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	95710	Prior authorization is required. For additional information please reference Electroencephalogram (EEG) Technologies, MP-DE-1088
Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, 2-12 hours; unmonitored	95711	Prior authorization is required. For additional information please reference Electroencephalogram (EEG) Technologies, MP-DE-1088
Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, 2-12 hours; with intermittent monitoring and maintenance	95712	Prior authorization is required. For additional information please reference Electroencephalogram (EEG) Technologies, MP-DE-1088
Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, 2-12 hours; with continuous, real-time monitoring and maintenance	95713	Prior authorization is required. For additional information please reference Electroencephalogram (EEG) Technologies, MP-DE-1088
Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, each increment of 12-26 hours; unmonitored	95714	Prior authorization is required. For additional information please reference Electroencephalogram (EEG) Technologies, MP-DE-1088
Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, each increment of 12-26 hours; with intermittent monitoring and maintenance	95715	Prior authorization is required. For additional information please reference Electroencephalogram (EEG) Technologies, MP-DE-1088
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	95716	Prior authorization is required. For additional information please reference Electroencephalogram (EEG) Technologies, MP-DE-1088
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	95717	Prior authorization is required. For additional information please reference Electroencephalogram (EEG) Technologies, MP-DE-1088
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)	95718	Prior authorization is required. For additional information please reference Electroencephalogram (EEG) Technologies, MP-DE-1088
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 bours, up to 26 hours of EEG recording, interpretation and report after each 24-hour period; without video	95719	Prior authorization is required. For additional information please reference Electroencephalogram (EEG) Technologies, MP-DE-1088
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)	95720	Prior authorization is required. For additional information please reference Electroencephalogram (EEG) Technologies, MP-DE-1088
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	95721	Prior authorization is required. For additional information please reference Electroencephalogram (EEG) Technologies, MP-DE-1088
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)	95722	Prior authorization is required. For additional information please reference Electroencephalogram (EEG) Technologies, MP-DE-1088
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	95723	Prior authorization is required. For additional information please reference Electroencephalogram (EEG) Technologies, MP-DE-1088
Electroencephalogram (EEC), 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)	95724	Prior authorization is required. For additional information please reference Electroencephalogram (EEG) Technologies, MP-DE-1088
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	95725	Prior authorization is required. For additional information please reference Electroencephalogram (EEG) Technologies, MP-DE-1088

Electroencephalogram (EEG), continuous recording, physician or other qualified health	95726	Prior authorization is required. For additional information please reference Electroencephalogram (EEG)
care professional review of recorded events,		Technologies, MP-DE-1088
analysis of spike and seizure detection,		
interpretation, and summary report, complete study; greater than 84 hours of EEG		
recording, with video (VEEG)		
Electroencephalogram (EEG) extended	95812	Prior authorization is required. For additional information please reference Electroencephalogram (EEG)
monitoring; 41-60 minutes		Technologies, MP-DE-1088
Electroencephalogram (EEG) extended monitoring: 61-119 minutes	95813	Prior authorization is required. For additional information please reference Electroencephalogram (EEG)
	05054	Technologies, MP-DE-1088
Functional cortical and subcortical mapping by stimulation and/or recording of electrodes	95961	Prior authorization is required. For additional information please reference Electroencephalogram (EEG) Technologies, MP-DE-1088
on brain surface, or of depth electrodes, to		Technologies, WF-DE-1000
provoke seizures or identify vital brain structures; initial hour of attendance by a		
physician or other qualified health care		
professional		
Functional cortical and subcortical mapping by stimulation and/or recording of electrodes	95962	Prior authorization is required. For additional information please reference Electroencephalogram (EEG)
on brain surface, or of depth electrodes, to		Technologies, MP-DE-1088
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)		
Initiation of selective head or total body	99184	Prior authorization is required. For additional information please reference Electroencephalogram (EEG)
hypothermia in the critically ill neonate,		Technologies, MP-DE-1088
includes appropriate patient selection by review of clinical, imaging and laboratory		
data, confirmation of esophageal temperature		
probe location, evaluation of amplitude EEG, supervision of controlled hypothermia, and		
assessment of patient tolerance of cooling		
Electroencephalogram (EEG); including	05010	Dailer with a single in the si
recording awake and asleep	95819	Prior authorization is required. For additional information please reference Electroencephalogram (EEG) Technologies, MP-DE-1088
Electroencephalogram (EEG); cerebral death evaluation only	95824	Prior authorization is required. For additional information please reference Electroencephalogram (EEG)
Corneal Surgery to Correct Refractive	Codes	Technologies, MP-DE-1088 Prior Authorization Requirement
Errors, Phototherapeutic Keratectomy		
and Corneal Collagen Cross-Linking		
Surgery		
Collagen cross-linking of cornea, including removal of the corneal epithelium, when	0402T	Prior authorization is required. For additional information please reference Corneal Surgery to Correct
performed, and intraoperative pachymetry,		Refractive Errors, Phototherapeutic Keratectomy and Corneal Collagen Cross-Linking Surgery, MP-DE-1099
when performed Keratomileusis	65760	
Relatorilleusis	03760	Prior authorization is required. For additional information please reference Corneal Surgery to Correct Refractive Errors, Phototherapeutic Keratectomy and Corneal Collagen Cross-Linking Surgery, MP-DE-1099
Keratophakia	65765	Prior authorization is required. For additional information please reference Corneal Surgery to Correct
		Refractive Errors, Phototherapeutic Keratectomy and Corneal Collagen Cross-Linking Surgery, MP-DE-1099
Epikeratoplasty	65767	Prior authorization is required. For additional information please reference Corneal Surgery to Correct
Epinoratopiasty	03707	Refractive Errors, Phototherapeutic Keratectomy and Corneal Collagen Cross-Linking Surgery, MP-DE-1099
Radial keratotomy	65771	Prior authorization is required. For additional information please reference Corneal Surgery to Correct
		Refractive Errors, Phototherapeutic Keratectomy and Corneal Collagen Cross-Linking Surgery, MP-DE-1099
Bone Mineral Density Studies	Codes	Prior Authorization Requirement
Bone Mineral Density Studies Computed tomography, bone mineral density	Codes 77078	Prior Authorization Requirement Prior authorization is required. For additional information please reference Bone Mineral Density Studies, MP-
Computed tomography, bone mineral density study, 1 or more sites, axial skeleton (eg,		
Computed tomography, bone mineral density study, 1 or more sites, axial skeleton (eg, hips, pelvis, spine) Fetal Surgery for Prenatally Diagnosed		Prior authorization is required. For additional information please reference Bone Mineral Density Studies, MP-
Computed tomography, bone mineral density study, 1 or more sites, axial skeleton (eg, hips, pelvis, spine) Fetal Surgery for Prenatally Diagnosed Malformations	77078 Codes	Prior authorization is required. For additional information please reference Bone Mineral Density Studies, MP- DE-1105 Prior Authorization Requirement
Computed tomography, bone mineral density study, 1 or more sites, axial skeleton (eg, hips, pelvis, spine) Fetal Surgery for Prenatally Diagnosed	77078	Prior authorization is required. For additional information please reference Bone Mineral Density Studies, MP- DE-1105 Prior Authorization Requirement Prior authorization is required. For additional information please reference Fetal Surgery for Prenatally
Computed tomography, bone mineral density study, 1 or more sittes, axial skeleton (eg, hips, pelvis, spine) Fetal Surgery for Prenatally Diagnosed Malformations Fetal shunt placement, including ultrasound	77078 Codes 59076	Prior authorization is required. For additional information please reference Bone Mineral Density Studies, MP- DE-1105 Prior Authorization Requirement Prior authorization is required. For additional information please reference Fetal Surgery for Prenatally Diagnosed Malformations, MP-DE-1110
Computed tomography, bone mineral density study. 1 or more sites, axial skeleton (eg. hips, pelvis, spine) Fetal Surgery for Prenatally Diagnosed Malformations Fetal shunt placement, including ultrasound guidance	77078 Codes	Prior authorization is required. For additional information please reference Bone Mineral Density Studies, MP- DE-1105 Prior Authorization Requirement Prior authorization is required. For additional information please reference Fetal Surgery for Prenatally
Computed tomography, bone mineral density study, 1 or more sites, axial skeleton (eg, hips, pelvis, spine) Fetal Surgery for Prenatally Diagnosed Malformations Fetal shunt placement, including ultrasound guidance Unlisted fetal invasive procedure, including ultrasound guidance, when performed Repair of sacrococcygeal teratoms in the	77078 Codes 59076	Prior authorization is required. For additional information please reference Bone Mineral Density Studies, MP- DE-1105 Prior Authorization Requirement Prior authorization is required. For additional information please reference Fetal Surgery for Prenatally Diagnosed Malformations, MP-DE-1110 Prior authorization is required. For additional information please reference Fetal Surgery for Prenatally Diagnosed Malformations, MP-DE-1110 Prior authorization is required. For additional information please reference Fetal Surgery for Prenatally Prior authorization is required. For additional information please reference Fetal Surgery for Prenatally
Computed tomography, bone mineral density study, 1 or more sites, axial skeleton (eg, hips, pelvis, spine) Fetal Surgery for Prenatally Diagnosed Malformations Fetal shunt placement, including ultrasound guidance Unlisted fetal invasive procedure, including ultrasound guidance, when performed Repair of sacrococcygeal teratoms in the fetus, procedure performed in utero	77078 Codes 59076 59897 52405	Prior authorization is required. For additional information please reference Bone Mineral Density Studies, MP-DE-1105 Prior Authorization Requirement Prior authorization is required. For additional information please reference Fetal Surgery for Prenatally Diagnosed Malformations, MP-DE-1110 Prior authorization is required. For additional information please reference Fetal Surgery for Prenatally Diagnosed Malformations, MP-DE-1110 Prior authorization is required. For additional information please reference Fetal Surgery for Prenatally Diagnosed Malformations, MP-DE-1110 Prior authorization is required. For additional information please reference Fetal Surgery for Prenatally Diagnosed Malformations, MP-DE-1110
Computed tomography, bone mineral density study, 1 or more sites, axial skeleton (eg, hips, pelvis, spine) Fetal Surgery for Prenatally Diagnosed Malformations Fetal shunt placement, including ultrasound guidance Unlisted fetal invasive procedure, including ultrasound guidance, when performed Repair of sacrococcygeal teratoms in the	77078 Codes 59076 59897	Prior authorization is required. For additional information please reference Bone Mineral Density Studies, MP- DE-1105 Prior Authorization Requirement Prior authorization is required. For additional information please reference Fetal Surgery for Prenatally Diagnosed Malformations, MP-DE-1110 Prior authorization is required. For additional information please reference Fetal Surgery for Prenatally Diagnosed Malformations, MP-DE-1110 Prior authorization is required. For additional information please reference Fetal Surgery for Prenatally Diagnosed Malformations, MP-DE-1110 Prior Authorization Requirement
Computed tomography, bone mineral density study, 1 or more sites, axial skeleton (eg, hips, pelvis, spine) Fetal Surgery for Prenatally Diagnosed Malformations Fetal shunt placement, including uitrasound guidance Unitsed fetal invasive procedure, including uitrasound guidance, when performed Repair of sacrococcygeal teratoms in the fetus, procedure performed in utero Urinary Incontinence Therapy	77078 Codes 59076 59897 \$22405 Codes	Prior authorization is required. For additional information please reference Bone Mineral Density Studies, MP-DE-1105 Prior Authorization Requirement Prior authorization is required. For additional information please reference Fetal Surgery for Prenatally Diagnosed Malformations, MP-DE-1110 Prior authorization is required. For additional information please reference Fetal Surgery for Prenatally Diagnosed Malformations, MP-DE-1110 Prior authorization is required. For additional information please reference Fetal Surgery for Prenatally Diagnosed Malformations, MP-DE-1110 Prior authorization is required. For additional information please reference Fetal Surgery for Prenatally Diagnosed Malformations, MP-DE-1110
Computed tomography, bone mineral density study, 1 or more sites, axial skeleton (eg. hips, pelvis, spine) Fetal Surgery for Prenatally Diagnosed Malformations Fetal shunt placement, including ultrasound guidance Unlisted fetal invasive procedure, including ultrasound guidance, when performed Repair of sacrococcygeal teratoma in the fetus, procedure performed in utero Urinary Incontinence Therapy Unlisted procedure, urinary system Fitting and insertion of pessary or other	77078 Codes 59076 59897 \$22405 Codes	Prior authorization is required. For additional information please reference Bone Mineral Density Studies, MP- DE-1105 Prior Authorization Requirement Prior authorization is required. For additional information please reference Fetal Surgery for Prenatally Diagnosed Malformations, MP-DE-1110 Prior authorization is required. For additional information please reference Fetal Surgery for Prenatally Diagnosed Malformations, MP-DE-1110 Prior authorization is required. For additional information please reference Fetal Surgery for Prenatally Diagnosed Malformations, MP-DE-1110 Prior authorization is required. For additional information please reference Fetal Surgery for Prenatally Diagnosed Malformations, MP-DE-1110 Prior authorization is required. For additional information please reference Urinary Incontinence Therapy, MP-DE-1117 Prior authorization is required. For additional information please reference Urinary Incontinence Therapy, Prior authorization is required. For additional information please reference Urinary Incontinence Therapy,
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Computed tomography, bone mineral density study, 1 or more sites, axial skeleton (eg, hips, pelvis, spine) Fetal Surgery for Prenatally Diagnosed Malformations Fetal shunt placement, including ultrasound guidance Unlisted fetal invasive procedure, including ultrasound guidance, when performed Repair of sacrococygeal teratoma in the fetus, procedure performed in utero Urinary Incontinence Therapy Unlisted procedure, urinary system Fitting and insertion of pessary or other intravaginal support device Biofeedback training, perinael muscles, anorectal or urethral spinicter, including EMG	77078 Codes 59076 59897 52405 Codes 53899	Prior authorization is required. For additional information please reference Bone Mineral Density Studies, MP- DE-1105 Prior Authorization Requirement Prior authorization is required. For additional information please reference Fetal Surgery for Prenatally Diagnosed Malformations, MP-DE-1110 Prior authorization is required. For additional information please reference Fetal Surgery for Prenatally Diagnosed Malformations, MP-DE-1110 Prior authorization is required. For additional information please reference Fetal Surgery for Prenatally Diagnosed Malformations, MP-DE-1110 Prior authorization is required. For additional information please reference Fetal Surgery for Prenatally Diagnosed Malformations, MP-DE-1110 Prior authorization is required. For additional information please reference Urinary Incontinence Therapy, MP-DE-1117 Prior authorization is required. For additional information please reference Urinary Incontinence Therapy, Prior authorization is required. For additional information please reference Urinary Incontinence Therapy,
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Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve;	33366	Prior authorization is required. For additional information please reference Transcatheter Aortic Valve Replacement, MP-DE-1125
transapical exposure (eg, left thoracotomy) Transcatheter aortic valve replacement	33367	Prior authorization is required. For additional information please reference Transcatheter Aortic Valve
(TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with		Replacement, MP-DE-1125
percutaneous peripheral arterial and venous cannulation (eg, femoral vessels) (List		
separately in addition to code for primary procedure)		
Transcatheter aortic valve replacement	33368	Prior authorization is required. For additional information please reference Transcatheter Aortic Valve
(TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with open		Replacement, MP-DE-1125
peripheral arterial and venous cannulation (eg, femoral, iliac, axillary vessels) (List		
separately in addition to code for primary procedure)		
Transcatheter aortic valve replacement	33369	Prior authorization is required. For additional information please reference Transcatheter Aortic Valve
(TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with central		Replacement, MP-DE-1125
arterial and venous cannulation (eg, aorta, right atrium, pulmonary artery) (List		
separately in addition to code for primary procedure)		
Transcatheter placement and subsequent removal of cerebral embolic protection	33370	Prior authorization is required. For additional information please reference Transcatheter Aortic Valve
device(s), including arterial access,		Replacement, MP-DE-1125
catheterization, imaging, and radiological supervision and interpretation, percutaneous		
(List separately in addition to code for primary procedure)		
Percutaneous transcatheter closure of paravalvular leak; initial occlusion device,	93591	Prior authorization is required. For additional information please reference Transcatheter Aortic Valve
aortic valve	Codes	Replacement, MP-DE-1125
Transcatheter Mitral Valve Repair/Replacement	Codes	Prior Authorization Requirement
Transcatheter mitral valve repair, percutaneous approach, including transseptal	33418	Prior authorization is required. For additional information please reference Transcatheter Mitral Valve Repair/Replacement, MP-DE-1126
puncture when performed; initial prosthesis		inepair/neplacement, WIF-DE-1120
Transcatheter mitral valve repair,	33419	Prior authorization is required. For additional information please reference Transcatheter Mitral Valve
percutaneous approach, including transseptal puncture when performed; additional		Repair/Replacement, MP-DE-1126
prosthesis(es) during same session (List separately in addition to code for primary		
procedure) Percutaneous transcatheter closure of	93590	Prior authorization is required. For additional information please reference Transcatheter Mitral Valve
paravalvular leak; initial occlusion device, mitral valve		Repair/Replacement, MP-DE-1126
Percutaneous transcatheter closure of paravalvular leak; each additional occlusion	93592	Prior authorization is required. For additional information please reference Transcatheter Mitral Valve
device (List separately in addition to code for		Repair/Replacement, MP-DE-1126
primary procedure) Electrical Bone Growth Stimulation	Codes	Prior Authorization Requirement
Spinal Electrical stimulation to aid bone healing;	20975	Prior authorization is required. For additional information please reference Electrical Bone Growth
invasive (operative) Osteogenesis stimulator, electrical,	E0748	Stimulation Spinal, MP-DE-1148 Prior authorization is required for billed charges greater than \$500. For additional information please
noninvasive, spinal applications		reference Electrical Bone Growth Stimulation Spinal, MP-DE-1148
Implantable Pulmonary Artery Pressure Measurement Device	Codes	Prior Authorization Requirement
Transcatheter implantation of wireless	33289	Prior authorization is required. For additional information please reference Implantable Pulmonary Artery
pulmonary artery pressure sensor for long- term hemodynamic monitoring, including		Pressure Measurement Device, MP-DE-1142
deployment and calibration of the sensor, right heart catheterization, selective		
pulmonary catheterization, radiological supervision and interpretation, and pulmonary		
artery angiography, when performed		
Remote monitoring of a wireless pulmonary artery pressure sensor for up to 30 days,	93264	Prior authorization is required. For additional information please reference Implantable Pulmonary Artery
including at least weekly downloads of pulmonary artery pressure recordings,		Pressure Measurement Device, MP-DE-1142
interpretation(s), trend analysis, and report(s)		
by a physician or other qualified health care professional		
Unlisted cardiovascular service or procedure	93799	Prior authorization is required. For additional information please reference Implantable Pulmonary Artery Pressure Measurement Device, MP-DE-1142
Fecal Microbiota Transplantation	Codes	Prior Authorization Requirement
Preparation of fecal microbiota for instillation, including assessment of donor specimen	44705	Prior authorization is required. For additional information please reference Fecal Microbiota Transplantation, MP-DE-1146
Unlisted procedure, small intestine	44799	Prior authorization is required. For additional information please reference Fecal Microbiota
		Transplantation, MP-DE-1146
Transcranial Magnetic Stimulation (TMS)	Codes	Prior Authorization Requirement
Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; initial, including	90867	Prior authorization is required. For additional information please reference Transcranial Magnetic
cortical mapping, motor threshold		Stimulation (TMS), MP-DE-1147
determination, delivery and management Therapeutic repetitive transcranial magnetic	90868	Prior authorization is required. For additional information please reference Transcranial Magnetic
stimulation (TMS) treatment; subsequent delivery and management, per session		Stimulation (TMS), MP-DE-1147
Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent	90869	Prior authorization is required. For additional information please reference Transcranial Magnetic Stimulation (TMS), MP-DE-1147
motor threshold re-determination with delivery and management		
Non-Spinal Bone Growth Stimulation	Codes	Prior Authorization Requirement
Electrical stimulation to aid bone healing; noninvasive (nonoperative)	20974	Prior authorization is required. For additional information please reference Non-Spinal Bone Growth Stimulation, MP-DE-1149
Electrical stimulation to aid bone healing; invasive (operative)	20975	Prior authorization is required. For additional information please reference Non-Spinal Bone Growth Stimulation, MP-DE-1149
Osteogenesis stimulator, electrical,	E0747	Prior authorization is required when charges are greater than \$500. For additional information please
noninvasive, other than spinal applications Cardiac Monitors	Codes	reference Non-Spinal Bone Growth Stimulation, MP-DE-1149 Prior Authorization Requirement
Insertion, subcutaneous cardiac rhythm	33285	Prior Authorization Requirement Prior authorization is required. For additional information please reference Cardiac Monitors, MP-DE-1152
monitor, including programming Removal, subcutaneous cardiac rhythm	33286	Prior authorization is required. For additional information please reference Cardiac Monitors, MP-DE-1152
	33230	. The determination is required. For additional information please reference caldiac informations, MP-DE-1132
monitor		

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External mobile cardiovascular telemetry with	93228	Prior authorization is required. For additional information please reference Cardiac Monitors, MP-DE-1152
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		
External mobile cardiovascular telemetry with electrocardiographic recording, concurrent	93229	Prior authorization is required. For additional information please reference Cardiac Monitors, MP-DE-1152
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		
External electrocardiographic recording for	93242	Prior authorization is required. For additional information please reference Cardiac Monitors, MP-DE-1152
more than 48 hours up to 7 days by continuous rhythm recording and storage;		
recording (includes connection and initial		
recording)		
External electrocardiographic recording for more than 48 hours up to 7 days by	93243	Prior authorization is required. For additional information please reference Cardiac Monitors, MP-DE-1152
continuous rhythm recording and storage;		
scanning analysis with report		
External electrocardiographic recording for	93244	Prior authorization is required. For additional information please reference Cardiac Monitors, MP-DE-1152
more than 48 hours up to 7 days by continuous rhythm recording and storage;		
review and interpretation	<u> </u>	
External electrocardiographic recording for	93246	Prior authorization is required. For additional information please reference Cardiac Monitors, MP-DE-1152
more than 7 days up to 15 days by continuous rhythm recording and storage;		
recording (includes connection and initial		
recording)		
External electrocardiographic recording for	93248	Prior authorization is required. For additional information please reference Cardiac Monitors, MP-DE-1152
more than 7 days up to 15 days by continuous rhythm recording and storage;		
review and interpretation		
Interrogation device evaluation (in person)	93261	Prior authorization is required. For additional information please reference Cardiac Monitors, MP-DE-1152
with analysis, review and report by a		
physician or other qualified health care professional, includes connection, recording		
and disconnection per patient encounter;		
implantable subcutaneous lead defibrillator		
system	T	
External patient and, when performed, auto activated electrocardiographic rhythm derived	93268	Prior authorization is required. For additional information please reference Cardiac Monitors, MP-DE-1152
event recording with symptom-related memory		
loop with remote download capability up to 30		
days, 24-hour attended monitoring; includes		
transmission, review and interpretation by a physician or other qualified health care		
professional		
External patient and, when performed, auto	93270	Prior authorization is required. For additional information please reference Cardiac Monitors, MP-DE-1152
activated electrocardiographic rhythm derived		
event recording with symptom-related memory loop with remote download capability up to 30		
days, 24-hour attended monitoring; recording		
(includes connection, recording, and		
disconnection) External patient and, when performed, auto	93271	Drive with a significant section of the additional information plans of the Condition Marsham AND DE 1152
activated electrocardiographic rhythm derived	932/1	Prior authorization is required. For additional information please reference Cardiac Monitors, MP-DE-1152
event recording with symptom-related memory		
loop with remote download capability up to 30		
days, 24-hour attended monitoring; transmission and analysis		
External patient and, when performed, auto	93272	Prior authorization is required. For additional information please reference Cardiac Monitors, MP-DE-1152
activated electrocardiographic rhythm derived		
event recording with symptom-related memory loop with remote download capability up to 30		
days, 24-hour attended monitoring; review		
and interpretation by a physician or other		
qualified health care professional		
Programming device evaluation (in person)	93285	Prior authorization is required. For additional information please reference Cardiac Monitors, MP-DE-1152
with iterative adjustment of the implantable	33203	. 110. Section (2000) 13 required. For additional information please reference Cardiac Monitors, MP-DE-1152
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; subcutaneous cardiac rhythm		
monitor system	02201	Drier authorization is required. For additional information above and the second of th
Interrogation device evaluation (in person) with analysis, review and report by a	93291	Prior authorization is required. For additional information please reference Cardiac Monitors, MP-DE-1152
physician or other qualified health care		
professional, includes connection, recording		
and disconnection per patient encounter; subcutaneous cardiac rhythm monitor		
system, including heart rhythm derived data		
analysis		
Interrogation device evaluation(s), (remote)	93297	Prior authorization is required. For additional information please reference Cardiac Monitors, MP-DE-1152
up to 30 days; implantable cardiovascular physiologic monitor system, including		
analysis of 1 or more recorded physiologic		
cardiovascular data elements from all internal		
and external sensors, analysis, review(s) and		
report(s) by a physician or other qualified health care professional		
Interrogation device evaluation(s), (remote)	93298	Prior authorization is required. For additional information please reference Cardiac Monitors, MP-DE-1152
up to 30 days; subcutaneous cardiac rhythm		place of the control
monitor system, including analysis of recorded heart rhythm data, analysis,		
recorded heart rhythm data, analysis, review(s) and report(s) by a physician or		
other qualified health care professional		
Bioengineered Skin	Codes	Prior Authorization Requirement
Tissue cultured skin autograft, trunk, arms,	15150	Prior authorization is required. For additional information please reference Bioengineered Skin, MP-DE-1129
legs; first 25 sq cm or less	lacaca.	
Tissue cultured skin autograft, trunk, arms, legs; additional 1 sq cm to 75 sq cm (List	15151	Prior authorization is required. For additional information please reference Bioengineered Skin, MP-DE-1129
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separately in addition to code for primary		

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Tissue cultured skin autograft, trunk, arms, legs; each additional 100 sq cm, or each	15152	Prior authorization is required. For additional information please reference Bioengineered Skin, MP-DE-1129
additional 1% of body area of infants and children, or part thereof (List separately in		
addition to code for primary procedure)		
Tissue cultured skin autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia,	15155	Prior authorization is required. For additional information please reference Bioengineered Skin, MP-DE-1129
hands, feet, and/or multiple digits; first 25 sq cm or less		
Tissue cultured skin autograft, face, scalp,	15156	Prior authorization is required. For additional information please reference Bioengineered Skin, MP-DE-1129
eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; additional		
1 sq cm to 75 sq cm (List separately in addition to code for primary procedure)		
Tissue cultured skin autograft, face, scalp,	15157	Prior authorization is required. For additional information please reference Bioengineered Skin, MP-DE-1129
eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each		
additional 100 sq cm, or each additional 1%		
of body area of infants and children, or part thereof (List separately in addition to code for		
primary procedure) Application of skin substitute graft to trunk,	15271	Prior authorization is required. For additional information please reference Bioengineered Skin, MP-DE-1129
arms, legs, total wound surface area up to	13271	The data lace of the data and t
100 sq cm; first 25 sq cm or less wound surface area		
Application of skin substitute graft to trunk,	15272	Prior authorization is required. For additional information please reference Bioengineered Skin, MP-DE-1129
100 sq cm; each additional 25 sq cm wound		
surface area, or part thereof (List separately in addition to code for primary procedure)		
Application of skin substitute graft to trunk,	15273	Prior authorization is required. For additional information please reference Bioengineered Skin, MP-DE-1129
arms, legs, total wound surface area greater	13273	Finor authorization is required. For additional information please releasing since side agrices ed Skill, MF-DE-1125
than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of		
infants and children	45274	District the second of the sec
Application of skin substitute graft to trunk, arms, legs, total wound surface area greater	15274	Prior authorization is required. For additional information please reference Bioengineered Skin, MP-DE-1129
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)	45275	District the state of the state
Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits,	15275	Prior authorization is required. For additional information please reference Bioengineered Skin, MP-DE-1129
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		
Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits,	15276	Prior authorization is required. For additional information please reference Bioengineered Skin, MP-DE-1129
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)		
Application of skin substitute graft to face,	15277	Prior authorization is required. For additional information please reference Bioengineered Skin, MP-DE-1129
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 Application of skin substitute graft to face,	15278	Prior authorization is required. For additional information please reference Bioengineered Skin, MP-DE-1129
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)		
Implantation of biologic implant (eg, acellular dermal matrix) for soft tissue reinforcement	15777	Prior authorization is required. For additional information please reference Bioengineered Skin, MP-DE-1129
(ie, breast, trunk) (List separately in addition		
to code for primary procedure) Tissue expander placement in breast	19357	Prior authorization is required. For additional information please reference Bioengineered Skin, MP-DE-1129
reconstruction, including subsequent expansion(s)		
Breast reconstruction; with latissimus dorsi	19361	Prior authorization is required. For additional information please reference Bioengineered Skin, MP-DE-1129
flap	40254	
Breast reconstruction; with free flap (eg, fTRAM, DIEP, SIEA, GAP flap)	19364	
		Prior authorization is required. For additional information please reference Bioengineered Skin, MP-DE-1129
Breast reconstruction; with single-pedicled	19367	Prior authorization is required. For additional information please reference Bioengineered Skin, MP-DE-1129 Prior authorization is required. For additional information please reference Bioengineered Skin, MP-DE-1129
Breast reconstruction; with single-pedicled transverse rectus abdominis myocutaneous (TRAM) flap	19367	
transverse rectus abdominis myocutaneous (TRAM) flap Breast reconstruction; with single-pedicled	19367 19368	
transverse rectus abdominis myocutaneous (TRAM) flap Breast reconstruction; with single-pedicled transverse rectus abdominis myocutaneous (TRAM) flap, requiring separate microvascular		Prior authorization is required. For additional information please reference Bioengineered Skin, MP-DE-1129
transverse rectus abdominis myocutaneous (TRAM) flap Breast reconstruction; with single-pedicied transverse rectus abdominis myocutaneous (TRAM) flap, requiring separate microvascular anastomosis (supercharging)	19368	Prior authorization is required. For additional information please reference Bioengineered Skin, MP-DE-1129 Prior authorization is required. For additional information please reference Bioengineered Skin, MP-DE-1129
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Ambulatory infusion pump, single or multiple channels, electric or battery operated, with administrative equipment, worn by patient	E0781	Prior authorization is required for billed charges greater than \$500. For additional information please reference Portable External Infusion Pump, MP-DE-1134
Parenteral infusion pump, stationary, single, or multichannel	E0791	Prior authorization is required for billed charges greater than \$500. For additional information please reference Portable External Infusion Pump, MP-DE-1134
Durable medical equipment, miscellaneous	E1399	Prior authorization is required for billed charges greater than \$500. For additional information please reference Portable External Infusion Pump, MP-DE-1134
Supplies for external noninsulin drug infusion pump, syringe type cartridge, sterile, each	к0552	Prior authorization is required for billed charges greater than \$500. For additional information please reference Portable External Infusion Pump, MP-DE-1134
Replacement battery for external infusion pump owned by patient, silver oxide, 1.5 volt,	K0601	Prior authorization is required for billed charges greater than \$500. For additional information please reference Portable External Infusion Pump, MP-DE-1134
each Replacement battery for external infusion pump owned by patient, silver oxide, 3 volt,	к0602	Prior authorization is required for billed charges greater than \$500. For additional information please reference Portable External Infusion Pump, MP-DE-1134
each Replacement battery for external infusion pump owned by patient, alkaline, 1.5 volt, each	к0603	Prior authorization is required for billed charges greater than \$500. For additional information please reference Portable External Infusion Pump, MP-DE-1134
Replacement battery for external infusion pump owned by patient, lithium, 3.6 volt, each	к0604	Prior authorization is required for billed charges greater than \$500. For additional information please reference Portable External Infusion Pump, MP-DE-1134
Replacement battery for external infusion pump owned by patient, lithium, 4.5 volt, each	K0605	Prior authorization is required for billed charges greater than \$500. For additional information please reference Portable External Infusion Pump, MP-DE-1134
Endovascular/Endoluminal Stent Grafts	Codes	Prior Authorization Requirement
Endovascular repair of infrarenal aorta and/or lika catroy(es) by deployment of an aorto-bi- lika en dograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the iliac bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the iliac bifurcation; for rupture including temporary aortic and/or lika balloon occlusion, when performed (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer, traumatic disruption)	34706	Prior authorization is required. For additional information please reference Endovascular/Endoluminal Stent Grafts, MP-DE-1157
Endovascular repair of iliac artery by deployment of an ilio-iliac tube endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, and all endograft extension(s) proximally to the eliac bifurcation, and treatment zone angioplasty/stenting, when performed, unilateral: for other than rupture (eg. for aneurysm, peseudoaneurysm, dissection, arteriovenous malformation)	34707	Prior authorization is required. For additional information please reference Endovascular/Endoluminal Stent Grafts, MP-DE-1157
Endovascular repair of iliac artery by deployment of an ilic-liac tube endograft including pre-procedure sizing and device selection, all nonselective catherderization(s), all associated radiological supervision and interpretation, and all endograft extension(s) proximally to the acritic bifurcation and distally to the liac bifurcation, and treatment zone angioplasty/stenting, when performed, unliateral; for rupture including temporary aortic and/or iliac balloon occlusion, when performed (eg. for aneurysm, pseudoaneurysm, dissection, arteriovenous malformation, traumatic disruption)	34708	Prior authorization is required. For additional information please reference Endovascular/Endoluminal Stent Grafts, MP-DE-1157
Flacement of extension prosthesis(es) distal to the common like artery(ise) or proximal to the renal artery(ise) for endovascular repair of infrarenal attorninal aortic or iliac aneurysm, faste aneurysm, dissection, penetrating uber, including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, and treatment zone angioplasty/stenting, when performed, per vessel treated (List separately in addition to code for primary procedure)	34709	Prior authorization is required. For additional information please reference Endovascular/Endoluminal Stent Grafts, MP-DE-1157
Delayed placement of distal or proximal extension proxthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, dissection, endoleak, or endograft migration, including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, and treatment zone angioplasty/stenting, when performed; initial vessel treated.	34710	Prior authorization is required. For additional information please reference Endovascular/Endoluminal Stent Grafts, MP-DE-1157
Delayed placement of distal or proximal extension proxthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, disse aneurysm, dissection, endoleak, or endograft migration, including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, and treatment zone angioplasty/stenting, when performed; each additional vessel treated (List separately in addition to code for primary procedure)	34711	Prior authorization is required. For additional information please reference Endovascular/Endoluminal Stent Grafts, MP-DE-1157
Transcatheter delivery of enhanced fixation device(s) to the endograft (eg, anchor, screw, tack) and all associated radiological	34712	Prior authorization is required. For additional information please reference Endovascular/Endoluminal Stent Grafts, MP-DE-1157 $ \frac{1}{2} \left(\frac{1}{2} \right) = \frac{1}{2} \left(\frac{1}{2} \right) \left(\frac{1}{$
artery for delivery of endograft through a large sheath (12 French or larger), including ultrasound guidance, when performed, unilateral (List separately in addition to code for primary procedure)	34713	Prior authorization is required. For additional information please reference Endovascular/Endoluminal Stent Grafts, MP-DE-1157
Open femoral artery exposure with creation of conduit for delivery of endovascular prosthesis or for establishment of cardiopulmonary bypass, by groin incision, unilateral (List separately in addition to code for primary procedure)	34714	Prior authorization is required. For additional information please reference Endovascular/Endoluminal Stent Grafts, MP-DE-1157

Ta	I	
Open axillary/subclavian artery exposure for delivery of endovascular prosthesis by infraclavicular or supraclavicular incision, unilateral (List separately in addition to code	34715	Prior authorization is required. For additional information please reference Endovascular/Endoluminal Stent Grafts, MP-DE-1157
for primary procedure)		
Open axillary/subclavian artery exposure with	34716	Prior authorization is required. For additional information please reference Endovascular/Endoluminal Stent
creation of conduit for delivery of endovascular prosthesis or for establishment		Grafts, MP-DE-1157
of cardiopulmonary bypass, by infraclavicular		
or supraclavicular incision, unilateral (List		
separately in addition to code for primary procedure)		
Endovascular placement of iliac artery	34808	Prior authorization is required. For additional information please reference Endovascular/Endoluminal Stent
occlusion device (List separately in addition		Grafts, MP-DE-1157
to code for primary procedure) Placement of femoral-femoral prosthetic graft	34813	Prior authorization is required. For additional information please reference Endovascular/Endoluminal Stent
during endovascular aortic aneurysm repair	54615	Grafts, MP-DE-1157
(List separately in addition to code for		·
primary procedure) Open repair of infrarenal aortic aneurysm or	34830	Prior authorization is required. For additional information please reference Endovascular/Endoluminal Stent
dissection, plus repair of associated arterial		Grafts, MP-DE-1157
trauma, following unsuccessful endovascular repair; tube prosthesis		
Open repair of infrarenal aortic aneurysm or	34831	Prior authorization is required. For additional information please reference Endovascular/Endoluminal Stent
dissection, plus repair of associated arterial trauma, following unsuccessful endovascular		Grafts, MP-DE-1157
repair; aorto-bi-iliac prosthesis		
Endovascular repair of visceral aorta (eg, aneurysm, pseudoaneurysm, dissection,	34841	Prior authorization is required. For additional information please reference Endovascular/Endoluminal Stent
penetrating ulcer, intramural hematoma, or		Grafts, MP-DE-1157
traumatic disruption) by deployment of a		
fenestrated visceral aortic endograft and all associated radiological supervision and		
interpretation, including target zone		
angioplasty, when performed; including one visceral artery endoprosthesis (superior		
mesenteric, celiac or renal artery)		
Endovascular repair of visceral aorta (eg,	34842	Prior authorization is required. For additional information please reference Endovascular/Endoluminal Stent
aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or		Grafts, MP-DE-1157
traumatic disruption) by deployment of a		
fenestrated visceral aortic endograft and all associated radiological supervision and		
interpretation, including target zone		
angioplasty, when performed; including two		
visceral artery endoprostheses (superior mesenteric, celiac and/or renal artery[s])		
Endovascular repair of visceral aorta (eg,	34843	Prior authorization is required. For additional information please reference Endovascular/Endoluminal Stent
aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or		Grafts, MP-DE-1157
traumatic disruption) by deployment of a		
fenestrated visceral aortic endograft and all		
associated radiological supervision and interpretation, including target zone		
angioplasty, when performed; including three		
visceral artery endoprostheses (superior mesenteric, celiac and/or renal artery[s])		
modification, collab allardi fortal artery[o])		
Endovascular repair of visceral aorta (eg, aneurysm, pseudoaneurysm, dissection,	34844	Prior authorization is required. For additional information please reference Endovascular/Endoluminal Stent
penetrating ulcer, intramural hematoma, or		Grafts, MP-DE-1157
traumatic disruption) by deployment of a		
fenestrated visceral aortic endograft and all associated radiological supervision and		
interpretation, including target zone		
angioplasty, when performed; including four or more visceral artery endoprostheses		
(superior mesenteric, celiac and/or renal		
artery[s]) Endovascular repair of visceral aorta and	34845	Prior authorization is required. For additional information please reference Endovascular/Endoluminal Stent
infrarenal abdominal aorta (eg, aneurysm,	54045	Grafts, MP-DE-1157
pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic		
disruption) with a fenestrated visceral aortic		
endograft and concomitant unibody or		
modular infrarenal aortic endograft and all associated radiological supervision and		
interpretation, including target zone		
angioplasty, when performed; including one visceral artery endoprosthesis (superior		
mesenteric, celiac or renal artery)		
Endovascular repair of visceral aorta and infrarenal abdominal aorta (eg, aneurysm,	34846	Prior authorization is required. For additional information please reference Endovascular/Endoluminal Stent
pseudoaneurysm, dissection, penetrating		Grafts, MP-DE-1157
ulcer, intramural hematoma, or traumatic		
endograft and concomitant unibody or		
modular infrarenal aortic endograft and all		
associated radiological supervision and interpretation, including target zone		
angioplasty, when performed; including two		
visceral artery endoprostheses (superior		
mesenteric, celiac and/or renal artery[s]) Endovascular repair of visceral aorta and	34847	Prior authorization is required. For additional information please reference Endovascular/Endoluminal Stent
infrarenal abdominal aorta (eg, aneurysm,		Grafts, MP-DE-1157
pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic		
disruption) with a fenestrated visceral aortic		
endograft and concomitant unibody or modular infrarenal aortic endograft and all		
associated radiological supervision and		
interpretation, including target zone		
angioplasty, when performed; including three visceral artery endoprostheses (superior		
mesenteric, celiac and/or renal artery[s])		
Endovascular repair of visceral aorta and	34848	Prior authorization is required. For additional information please reference Endovascular/Endoluminal Stent
infrarenal abdominal aorta (eg, aneurysm,		Grafts, MP-DE-1157
pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic		
disruption) with a fenestrated visceral aortic		
endograft and concomitant unibody or		•
endograft and concomitant unibody or modular infrarenal aortic endograft and all		
endograft and concomitant unibody or modular infrarenal aortic endograft and all associated radiological supervision and interpretation, including target zone		
endograft and concomitant unibody or modular infrarenal aortic endograft and all associated radiological supervision and interpretation, including target zone angioplasty, when performed; including four		
endograft and concomitant unibody or modular infrarenal aortic endograft and all associated radiological supervision and interpretation, including target zone		
endograft and concomitant unibody or modular infrarenal aortic endograft and all associated radiological supervision and interpretation, including target zone angioplasty, when performed; including four or more visceral artery endoprostheses		

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Secretary productions of the composition of the com			
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Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter	11303	Prior authorization is required. For additional information please reference Removal of Benign or Premalignant Skin Lesions, MP-DE-1130
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Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter over 2.0 cm	11308	Prior authorization is required. For additional information please reference Removal of Benign or Premalignant Skin Lesions, MP-DE-1130
Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.5 cm or less	11310	Prior authorization is required. For additional information please reference Removal of Benign or Premalignant Skin Lesions, MP-DE-1130
Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.6 to 1.0 cm	11311	Prior authorization is required. For additional information please reference Removal of Benign or Premalignant Skin Lesions, MP-DE-1130
lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 1.1 to 2.0 cm	11312	Prior authorization is required. For additional information please reference Removal of Benign or Premalignant Skin Lesions, MP-DE-1130
Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter over 2.0 cm	11313	Prior authorization is required. For additional information please reference Removal of Benign or Premailgnant Skin Lesions, MP-DE-1130
Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 0.5 cm or less	11400	Prior authorization is required. For additional information please reference Removal of Benign or Premalignant Skin Lesions, MP-DE-1130
Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 0.6 to 1.0 cm	11401	Prior authorization is required. For additional information please reference Removal of Benign or Premalignant Skin Lesions, MP-DE-1130
Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 1.1 to 2.0 cm	11402	Prior authorization is required. For additional information please reference Removal of Benign or Premalignant Skin Lesions, MP-DE-1130
Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 2.1 to 3.0 cm	11403	Prior authorization is required. For additional information please reference Removal of Benign or Premalignant Skin Lesions, MP-DE-1130
Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter over 4.0 cm	11406	Prior authorization is required. For additional information please reference Removal of Benign or Premalignant Skin Lesions, MP-DE-1130
Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.5 cm or less	11420	Prior authorization is required. For additional information please reference Removal of Benign or Premalignant Skin Lesions, MP-DE-1130
Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.6 to 1.0 cm	11421	Prior authorization is required. For additional information please reference Removal of Benign or Premalignant Skin Lesions, MP-DE-1130
Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 1.1 to 2.0 cm	11422	Prior authorization is required. For additional information please reference Removal of Benign or Premalignant Skin Lesions, MP-DE-1130
Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 2.1 to 3.0 cm	11423	Prior authorization is required. For additional information please reference Removal of Benign or Premalignant Skin Lesions, MP-DE-1130
Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 3.1 to 4.0 cm	11424	Prior authorization is required. For additional information please reference Removal of Benign or Premalignant Skin Lesions, MP-DE-1130
Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter over 4.0 cm	11426	Prior authorization is required. For additional information please reference Removal of Benign or Premalignant Skin Lesions, MP-DE-1130
Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 0.5 cm	11440	Prior authorization is required. For additional information please reference Removal of Benign or Premalignant Skin Lesions, MP-DE-1130
or less Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 0.6 to 1.0 cm	11441	Prior authorization is required. For additional information please reference Removal of Benign or Premalignant Skin Lesions, MP-DE-1130
Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 1.1 to 2.0 cm	11442	Prior authorization is required. For additional information please reference Removal of Benign or Premalignant Skin Lesions, MP-DE-1130
Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 2.1 to 3.0 cm	11443	Prior authorization is required. For additional information please reference Removal of Benign or Premalignant Skin Lesions, MP-DE-1130
Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 3.1 to 4.0 cm	11444	Prior authorization is required. For additional information please reference Removal of Benign or Premalignant Skin Lesions, MP-DE-1130
4.0 cm Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter over 4.0 cm	11446	Prior authorization is required. For additional information please reference Removal of Benign or Premalignant Skin Lesions, MP-DE-1130
4.0 cm Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); first lesion	17000	Prior authorization is required. For additional information please reference Removal of Benign or Premalignant Skin Lesions, MP-DE-1130
Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); second through 14 lesions, each (List separately in addition to	17003	Prior authorization is required. For additional information please reference Removal of Benign or Premalignant Skin Lesions, MP-DE-1130
code for first lesion) Destruction (eg. laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg. actinic keratoses), 15 or more lesions	17004	Prior authorization is required. For additional information please reference Removal of Benign or Premalignant Skin Lesions, MP-DE-1130
Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; up to 14 lesions	17110	Prior authorization is required. For additional information please reference Removal of Benign or Premalignant Skin Lesions, MP-DE-1130

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Destruction (eg, laser surgery,	17111	Prior authorization is required. For additional information please reference Removal of Benign or
electrosurgery, cryosurgery, chemosurgery,		Premalignant Skin Lesions, MP-DE-1130
surgical curettement), of benign lesions other		
than skin tags or cutaneous vascular proliferative lesions; 15 or more lesions		
Responsive Neurostimulation for the	Codes	Prior Authorization Requirement
Treatment of Refractory Partial Epilepsy	codes	Filor Authorization Requirement
	CARCO	
Twist drill or burr hole(s) for implantation of neurostimulator electrodes, cortical	61850	Prior authorization is required. For additional information please reference Responsive Neurostimulation for
		the Treatment of Refractory Partial Epilepsy, MP-DE-1131
Craniectomy or craniotomy for implantation of	61860	Prior authorization is required. For additional information please reference Responsive Neurostimulation for
neurostimulator electrodes, cerebral, cortical		the Treatment of Refractory Partial Epilepsy, MP-DE-1131
Twist drill, burr hole, craniotomy, or	61863	Prior authorization is required. For additional information please reference Responsive Neurostimulation for
craniectomy with stereotactic implantation of	01003	the Treatment of Refractory Partial Epilepsy, MP-DE-1131
neurostimulator electrode array in subcortical		the freatment of Netractory Farthal Epitepsy, Wil-DE-1131
site (eg, thalamus, globus pallidus,		
subthalamic nucleus, periventricular,		
periaqueductal gray), without use of		
intraoperative microelectrode recording; first array		
Twist drill, burr hole, craniotomy, or	61864	Drieg authorization is required. For additional information place reference Personnius Neurostimulation for
craniectomy with stereotactic implantation of	01804	Prior authorization is required. For additional information please reference Responsive Neurostimulation for
neurostimulator electrode array in subcortical		the Treatment of Refractory Partial Epilepsy, MP-DE-1131
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)		
Twist drill, burr hole, craniotomy, or	61867	Prior authorization is required. For additional information please reference Responsive Neurostimulation for
craniectomy with stereotactic implantation of	01807	the Treatment of Refractory Partial Epilepsy, MP-DE-1131
neurostimulator electrode array in subcortical		the freatment of Netractory Farthal Epitepsy, Wil-DE-1131
site (eg, thalamus, globus pallidus,		
subthalamic nucleus, periventricular,		
periaqueductal gray), with use of		
intraoperative microelectrode recording; first	1	
Twist drill, burr hole, craniotomy, or	61060	Drive authorization is required. For additional information also reference Personalization (Control of the Control of the Cont
craniectomy with stereotactic implantation of	61868	Prior authorization is required. For additional information please reference Responsive Neurostimulation for
neurostimulator electrode array in subcortical		the Treatment of Refractory Partial Epilepsy, MP-DE-1131
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) Revision or removal of intracranial	54000	
neurostimulator electrodes	61880	Prior authorization is required. For additional information please reference Responsive Neurostimulation for
		the Treatment of Refractory Partial Epilepsy, MP-DE-1131
Insertion or replacement of cranial	61885	Prior authorization is required. For additional information please reference Responsive Neurostimulation for
neurostimulator pulse generator or receiver, direct or inductive coupling; with connection		the Treatment of Refractory Partial Epilepsy, MP-DE-1131
to a single electrode array		
Insertion or replacement of cranial	61886	Prior authorization is required. For additional information please reference Responsive Neurostimulation for
neurostimulator pulse generator or receiver,		the Treatment of Refractory Partial Epilepsy, MP-DE-1131
direct or inductive coupling; with connection		the realment of herioticity is a tild Epiteps), in the 1131
to 2 or more electrode arrays		
Revision or removal of cranial neurostimulator	61888	Prior authorization is required. For additional information please reference Responsive Neurostimulation for
pulse generator or receiver		the Treatment of Refractory Partial Epilepsy, MP-DE-1131
Electronic analysis of implanted	95970	Prior authorization is required. For additional information please reference Responsive Neurostimulation for
neurostimulator pulse generator/transmitter		the Treatment of Refractory Partial Epilepsy, MP-DE-1131
(eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling,		
burst, magnet mode, dose lockout, patient		
selectable parameters, responsive		
neurostimulation, detection algorithms, closed		
loop parameters, and passive parameters) by		
physician or other qualified health care		
professional; with brain, cranial nerve, spinal		
cord, peripheral nerve, or sacral nerve, neurostimulator pulse generator/transmitter,		
without programming		
Electronic analysis of implanted	95976	Prior authorization is required. For additional information please reference Responsive Neurostimulation for
neurostimulator pulse generator/transmitter		the Treatment of Refractory Partial Epilepsy, MP-DE-1131
(eg, contact group[s], interleaving, amplitude,		
pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient		
selectable parameters, responsive		
neurostimulation, detection algorithms, closed		
loop parameters, and passive parameters) by		
physician or other qualified health care		
professional; with simple cranial nerve		
neurostimulator pulse generator/transmitter	1	
programming by physician or other qualified health care professional		
nous care professional		
Electronic analysis of implanted	95977	Prior authorization is required. For additional information please reference Responsive Neurostimulation for
neurostimulator pulse generator/transmitter		the Treatment of Refractory Partial Epilepsy, MP-DE-1131
(eg, contact group[s], interleaving, amplitude,		y p y y y y
pulse width, frequency [Hz], on/off cycling,		
burst, magnet mode, dose lockout, patient		
selectable parameters, responsive neurostimulation, detection algorithms, closed		
loop parameters, and passive parameters) by		
physician or other qualified health care		
professional; with complex cranial nerve		
neurostimulator pulse generator/transmitter		
programming by physician or other qualified		
health care professional		
Electronic analysis of implanted	95983	Prior authorization is required. For additional information please reference Responsive Neurostimulation for
neurostimulator pulse generator/transmitter		the Treatment of Refractory Partial Epilepsy, MP-DE-1131
(eg, contact group[s], interleaving, amplitude,		and the second s
pulse width, frequency [Hz], on/off cycling,	1	
burst, magnet mode, dose lockout, patient		
	I	
selectable parameters, responsive		
selectable parameters, responsive neurostimulation, detection algorithms, closed		
selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by		
selectable parameters, responsive neurostimulation, detection algorithms, closed		
selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain neurostimulator pulse generator/transmitter programming, first 15		
selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain neurostimulator pulse generator/transmitter programming, first 15 minutes face-to-face time with physician or		
selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain neurostimulator pulse generator/transmitter programming, first 15		

Electronic analysis of implanted neurostimulator pulse generator/transmitter	95984	Prior authorization is required. For additional information please reference Responsive Neurostimulation for the Treatment of Refractory Partial Epilepsy, MP-DE-1131
(eg, contact group[s], interleaving, amplitude,		the freatment of kerractory Partial Epirepsy, MP-DE-1131
pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient		
selectable parameters, responsive		
neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by		
physician or other qualified health care		
professional; with brain neurostimulator pulse generator/transmitter programming, each		
additional 15 minutes face-to-face time with		
physician or other qualified health care professional (List separately in addition to		
code for primary procedure)		
Transesophageal Endoscopic Therapies	Codes	Prior Authorization Requirement
for Gastroesophageal Reflux Disease		·
Esophagoscopy, rigid, transoral; with directed submucosal injection(s), any substance	43192	Prior authorization is required. For additional information please reference Transesophageal Endoscopic Therapies for Gastroesophageal Reflux Disease, MP-DE-1139
Esophagoscopy, flexible, transoral; with directed submucosal injection(s), any	43201	Prior authorization is required. For additional information please reference Transesophageal Endoscopic Therapies for Gastroesophageal Reflux Disease, MP-DE-1139
substance Esophagogastroduodenoscopy, flexible.	42240	1 2
transoral; with esophagogastric fundoplasty,	43210	Prior authorization is required. For additional information please reference Transesophageal Endoscopic Therapies for Gastroesophageal Reflux Disease, MP-DE-1139
partial or complete, includes duodenoscopy when performed		
Esophagoscopy, flexible, transoral; with	43212	Prior authorization is required. For additional information please reference Transesophageal Endoscopic
placement of endoscopic stent (includes pre- and post-dilation and guide wire passage,		Therapies for Gastroesophageal Reflux Disease, MP-DE-1139
when performed)		
Esophagogastroduodenoscopy, flexible, transoral; with directed submucosal	43236	Prior authorization is required. For additional information please reference Transesophageal Endoscopic
injection(s), any substance		Therapies for Gastroesophageal Reflux Disease, MP-DE-1139
Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-	43253	Prior authorization is required. For additional information please reference Transesophageal Endoscopic Therapies for Gastroesophageal Reflux Disease, MP-DE-1139
guided transmural injection of diagnostic or		malapies io sustroesopriagear neriux disease, ivii -bt-1155
therapeutic substance(s) (eg, anesthetic, neurolytic agent) or fiducial marker(s)		
(includes endoscopic ultrasound examination of the esophagus, stomach, and either the		
duodenum or a surgically altered stomach		
where the jejunum is examined distal to the anastomosis)		
Esophagogastroduodenoscopy, flexible,	43257	Prior authorization is required. For additional information please reference Transesophageal Endoscopic
transoral; with delivery of thermal energy to the muscle of lower esophageal sphincter		Therapies for Gastroesophageal Reflux Disease, MP-DE-1139
and/or gastric cardia, for treatment of		
gastroesophageal reflux disease Esophagogastroduodenoscopy, flexible,	43266	Prior authorization is required. For additional information please reference Transesophageal Endoscopic
transoral; with placement of endoscopic stent	43200	Therapies for Gastroesophageal Reflux Disease, MP-DE-1139
(includes pre- and post-dilation and guide wire passage, when performed)		
Unlisted procedure, esophagus	43499	Prior authorization is required. For additional information please reference Transesophageal Endoscopic
Unlisted procedure, stomach	43999	Therapies for Gastroesophageal Reflux Disease, MP-DE-1139
onisted procedure, storiach	43999	Prior authorization is required. For additional information please reference Transesophageal Endoscopic Therapies for Gastroesophageal Reflux Disease, MP-DE-1139
Unlisted laparoscopy procedure, stomach	43659	Prior authorization is required. For additional information please reference Transesophageal Endoscopic
		Therapies for Gastroesophageal Reflux Disease, MP-DE-1139
Interspinous and Interlaminar Stabilization/Distraction Devices	Codes	Prior Authorization Requirement
Interspinous and Interlaminar Stabilization/Distraction Devices Unlisted procedure, spine	22899	Prior Authorization Requirement Prior authorization is required. For additional information please reference Interspinous and Interlaminar
Stabilization/Distraction Devices Unlisted procedure, spine	22899	Prior authorization is required. For additional information please reference Interspinous and Interlaminar Stabilization/Distraction Devices, MP-0E-1155
Stabilization/Distraction Devices		Prior authorization is required. For additional information please reference Interspinous and Interlaminar Stabilization/Distraction Devices, MP-DE-1155 Prior authorization is required. For additional information please reference Interspinous and Interlaminar
Stabilization/Distraction Devices Unlisted procedure, spine Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when	22899	Prior authorization is required. For additional information please reference Interspinous and Interlaminar Stabilization/Distraction Devices, MP-0E-1155
Stabilization/Distraction Devices Unlisted procedure, spine Insertion of interlaminar/interspinous process stabilization/distraction device, without	22899	Prior authorization is required. For additional information please reference Interspinous and Interlaminar Stabilization/Distraction Devices, MP-DE-1155 Prior authorization is required. For additional information please reference Interspinous and Interlaminar
Stabilization/Distraction Devices Unlisted procedure, spine Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level Insertion of interlaminar/interspinous process	22899	Prior authorization is required. For additional information please reference Interspinous and Interlaminar Stabilization/Distraction Devices, MP-DE-1155 Prior authorization is required. For additional information please reference Interspinous and Interlaminar Stabilization/Distraction Devices, MP-DE-1155 Prior authorization is required. For additional information please reference Interspinous and Interlaminar
Stabilization/Distraction Devices Unlisted procedure, spine Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with pen decompression, lumbar; single level Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when	22899 22867	Prior authorization is required. For additional information please reference Interspinous and Interlaminar Stabilization/Distraction Devices, MP-DE-1155 Prior authorization is required. For additional information please reference Interspinous and Interlaminar Stabilization/Distraction Devices, MP-DE-1155
Stabilization/Distraction Devices Unlisted procedure, spine Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; performed, with open decompression, lumbar;	22899 22867	Prior authorization is required. For additional information please reference Interspinous and Interlaminar Stabilization/Distraction Devices, MP-DE-1155 Prior authorization is required. For additional information please reference Interspinous and Interlaminar Stabilization/Distraction Devices, MP-DE-1155 Prior authorization is required. For additional information please reference Interspinous and Interlaminar
Stabilization/Distraction Devices Unlisted procedure, spine Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with pen decompression, lumbar, single level Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with pen decompression, lumbar, second level (List separately in addition to code for primary procedure)	22899 22867 22868	Prior authorization is required. For additional information please reference Interspinous and Interlaminar Stabilization/Distraction Devices, MP-DE-1155 Prior authorization is required. For additional information please reference Interspinous and Interlaminar Stabilization/Distraction Devices, MP-DE-1155 Prior authorization is required. For additional information please reference Interspinous and Interlaminar Stabilization/Distraction Devices, MP-DE-1155
Stabilization/Distraction Devices Unlisted procedure, spine Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with peen decompression, lumbar; single level 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	22899 22867	Prior authorization is required. For additional information please reference Interspinous and Interlaminar Stabilization/Distraction Devices, MP-DE-1155 Prior authorization is required. For additional information please reference Interspinous and Interlaminar Stabilization/Distraction Devices, MP-DE-1155 Prior authorization is required. For additional information please reference Interspinous and Interlaminar Stabilization/Distraction Devices, MP-DE-1155 Prior authorization is required. For additional information please reference Interspinous and Interlaminar Stabilization/Distraction Devices, MP-DE-1155
Stabilization/Distraction Devices Unlisted procedure, spine Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with peen decompression, lumbar; single level 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) Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image	22899 22867 22868	Prior authorization is required. For additional information please reference Interspinous and Interlaminar Stabilization/Distraction Devices, MP-DE-1155 Prior authorization is required. For additional information please reference Interspinous and Interlaminar Stabilization/Distraction Devices, MP-DE-1155 Prior authorization is required. For additional information please reference Interspinous and Interlaminar Stabilization/Distraction Devices, MP-DE-1155
Stabilization/Distraction Devices Unlisted procedure, spine Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level 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) Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level	22899 22867 22868 22869	Prior authorization is required. For additional information please reference Interspinous and Interlaminar Stabilization/Distraction Devices, MP-DE-1155 Prior authorization is required. For additional information please reference Interspinous and Interlaminar Stabilization/Distraction Devices, MP-DE-1155 Prior authorization is required. For additional information please reference Interspinous and Interlaminar Stabilization/Distraction Devices, MP-DE-1155 Prior authorization is required. For additional information please reference Interspinous and Interlaminar Stabilization/Distraction Devices, MP-DE-1155 Prior authorization is required. For additional information please reference Interspinous and Interlaminar Stabilization/Distraction Devices, MP-DE-1155
Stabilization/Distraction Devices Unlisted procedure, spine Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with pean decompression, lumbar; single level 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) Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level	22899 22867 22868	Prior authorization is required. For additional information please reference Interspinous and Interlaminar Stabilization/Distraction Devices, MP-DE-1155 Prior authorization is required. For additional information please reference Interspinous and Interlaminar Stabilization/Distraction Devices, MP-DE-1155 Prior authorization is required. For additional information please reference Interspinous and Interlaminar Stabilization/Distraction Devices, MP-DE-1155 Prior authorization is required. For additional information please reference Interspinous and Interlaminar Stabilization/Distraction Devices, MP-DE-1155 Prior authorization is required. For additional information please reference Interspinous and Interlaminar Stabilization/Distraction Devices, MP-DE-1155
Stabilization/Distraction Devices Unlisted procedure, spine Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level 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) Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion including image of the process of the performed, lumbar; single level	22899 22867 22868 22869	Prior authorization is required. For additional information please reference Interspinous and Interlaminar Stabilization/Distraction Devices, MP-DE-1155 Prior authorization is required. For additional information please reference Interspinous and Interlaminar Stabilization/Distraction Devices, MP-DE-1155 Prior authorization is required. For additional information please reference Interspinous and Interlaminar Stabilization/Distraction Devices, MP-DE-1155 Prior authorization is required. For additional information please reference Interspinous and Interlaminar Stabilization/Distraction Devices, MP-DE-1155 Prior authorization is required. For additional information please reference Interspinous and Interlaminar Stabilization/Distraction Devices, MP-DE-1155
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Transcatheter therapy, embolization, any method, radiological supervision and interpretation	75894	Prior authorization is required. For additional information please reference Treatment of Abnormal Uterine Bleeding and Fibroids, MP-DE-1156
Laparoscopy, surgical, ablation of uterine fibroid(s) including intraoperative ultrasound guidance and monitoring, radiofrequency	58674	Prior authorization is required. For additional information please reference Treatment of Abnormal Uterine Bleeding and Fibroids, MP-DE-1156
Endometrial ablation, thermal, without hysteroscopic guidance	58353	Prior authorization is required. For additional information please reference Treatment of Abnormal Uterine Bleeding and Fibroids, MP-DE-1156
Endometrial cryoablation with ultrasonic guidance, including endometrial curettage, when performed	58356	Prior authorization is required. For additional information please reference Treatment of Abnormal Uterine Bleeding and Fibroids, MP-DE-1156
Hysteroscopy, surgical; with endometrial ablation (eg, endometrial resection,	58563	Prior authorization is required. For additional information please reference Treatment of Abnormal Uterine Bleeding and Fibroids, MP-DE-1156
electrosurgical ablation, thermoablation) Treatment of Prostate	Codes	Prior Authorization Requirement
Cystourethroscopy, with insertion of permanent adjustable transprostatic implant;	52441	Prior authorization is required. For additional information please reference Treatment of Prostate, MP-DE-
single implant Cystourethroscopy, with insertion of	52442	Prior authorization is required. For additional information please reference Treatment of Prostate, MP-DE-
permanent adjustable transprostatic implant; each additional permanent adjustable transprostatic implant (List separately in addition to code for primary procedure)		1158
Transurethral incision of prostate	52450	Prior authorization is required. For additional information please reference Treatment of Prostate, MP-DE- 1158
Transurethral electrosurgical resection of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)	52601	Prior authorization is required. For additional information please reference Treatment of Prostate, MP-DE- 1158
Transurethral resection; residual or regrowth of obstructive prostate tissue including control of postoperative bleeding, compete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)	52630	Prior authorization is required. For additional information please reference Treatment of Prostate, MP-DE- 1158
Transurethral resection; of postoperative bladder neck contracture	52640	Prior authorization is required. For additional information please reference Treatment of Prostate, MP-DE- 1158
Laser coagulation of prostate, including	52647	Prior authorization is required. For additional information please reference Treatment of Prostate, MP-DE-
control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included if performed)		1158
Laser vaporization of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed)	52648	Prior authorization is required. For additional information please reference Treatment of Prostate, MP-DE- 1158
Laser enucleation of the prostate with morcellation, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed)	52649	Prior authorization is required. For additional information please reference Treatment of Prostate, MP-DE- 1158
Transurethral destruction of prostate tissue;	53850	Prior authorization is required. For additional information please reference Treatment of Prostate, MP-DE-
by microwave thermotherapy Transurethral destruction of prostate tissue;	53852	1158 Prior authorization is required. For additional information please reference Treatment of Prostate, MP-DE-
by radiofrequency thermotherapy Transurethral destruction of prostate tissue;	53854	1158 Prior authorization is required. For additional information please reference Treatment of Prostate, MP-DE-
by radiofrequency generated water vapor thermotherapy Prostatectomy (including control of	55821	1158 Prior authorization is required. For additional information please reference Treatment of Prostate, MP-DE-
postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy); suprapubic, subtotal, 1 or 2 stages		1158
Prostatectomy (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy); retropubic,	55831	Prior authorization is required. For additional information please reference Treatment of Prostate, MP-DE- 1158
subtotal Prostatectomy, perineal, subtotal (including control of postoperative bleeding, vasectomy,	55801	Prior authorization is required. For additional information please reference Treatment of Prostate, MP-DE- 1158
meatotomy, urethral calibration and/or dilation, and internal urethrotomy) Prostatectomy, perineal radical;	55810	Prior authorization is required. For additional information please reference Treatment of Prostate, MP-DE-
Prostatectomy, perineal radical; with lymph	55812	1158 Prior authorization is required. For additional information please reference Treatment of Prostate, MP-DE-
node biopsy(s) (limited pelvic lymphadenectomy) Prostatectomy, perineal radical; with bilateral	55815	1158 Prior authorization is required. For additional information please reference Treatment of Prostate, MP-DE-
pelvic lymphadenectomy, including external iliac, hypogastric and obturator nodes	33013	Prior authorization is required. For additional information please reference Treatment of Prostate, MP-Dt- 1158
Prostatectomy, retropubic radical, with or without nerve sparing;	55840	Prior authorization is required. For additional information please reference Treatment of Prostate, MP-DE- 1158
Prostatectomy, retropubic radical, with or without nerve sparing; with lymph node biopsy(s) (limited pelvic lymphadenectomy)	55842	Prior authorization is required. For additional information please reference Treatment of Prostate, MP-DE- 1158
prostatectomy, retropubic radical, with or without nerve sparing; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes	55845	Prior authorization is required. For additional information please reference Treatment of Prostate, MP-DE- 1158
Cryosurgical ablation of the prostate (includes ultrasonic guidance and monitoring)	55873	Prior authorization is required. For additional information please reference Treatment of Prostate, MP-DE- 1158
Ablation of malignant prostate tissue, transrectal, with high intensity-focused ultrasound (HIFU), including ultrasound quidance	55880	Prior authorization is required. For additional information please reference Treatment of Prostate, MP-DE- 1158
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	37243	Prior authorization is required. For additional information please reference Treatment of Prostate, MP-DE- 1158
Insertion of a temporary prostatic urethral stent, including urethral measurement	53855	Prior authorization is required. For additional information please reference Treatment of Prostate, MP-DE- 1158
Cardiac Ablation Procedure Operative ablation of supraventricular arrhythmogenic focus or pathway (eg. Wolff-Parkinson-White, atrioventricular node reentry), tract(s) and/or focus (foci); without cardiopulmonary bypass	Codes 33250	Prior authorization Requirement Prior authorization is required. For additional information please reference Cardiac Ablation Procedure, MP- DE-1187

Operative obletion of augrenmentricular	22254	Daisson, the single in consisted for additional information plants of control Condition Abbetica December 840
Operative ablation of supraventricular arrhythmogenic focus or pathway (eg, Wolff-	33251	Prior authorization is required. For additional information please reference Cardiac Ablation Procedure, MP- DF-1187
Parkinson-White, atrioventricular node re- entry), tract(s) and/or focus (foci); with		
cardiopulmonary bypass		
Operative tissue ablation and reconstruction	33254	Prior authorization is required. For additional information please reference Cardiac Ablation Procedure, MP-
of atria, limited (eg, modified maze procedure)		DE-1187
Operative tissue ablation and reconstruction of atria, extensive (eg, maze procedure);	33255	Prior authorization is required. For additional information please reference Cardiac Ablation Procedure, MP- DE-1187
without cardiopulmonary bypass		-
Operative tissue ablation and reconstruction of atria, extensive (eg, maze procedure); with	33256	Prior authorization is required. For additional information please reference Cardiac Ablation Procedure, MP-
cardiopulmonary bypass		DE-1187
Operative tissue ablation and reconstruction of atria, performed at the time of other	33257	Prior authorization is required. For additional information please reference Cardiac Ablation Procedure, MP- DE-1187
cardiac procedure(s), limited (eg, modified		DC-1107
maze procedure) (List separately in addition to code for primary procedure)		
Operative tissue ablation and reconstruction of atria, performed at the time of other	33258	Prior authorization is required. For additional information please reference Cardiac Ablation Procedure, MP-
cardiac procedure(s), extensive (eg, maze		DE-1187
procedure), without cardiopulmonary bypass (List separately in addition to code for		
primary procedure)		
Operative tissue ablation and reconstruction of atria, performed at the time of other	33259	Prior authorization is required. For additional information please reference Cardiac Ablation Procedure, MP- DE-1187
cardiac procedure(s), extensive (eg, maze		DC1107
procedure), with cardiopulmonary bypass (List separately in addition to code for		
primary procedure)		
Operative ablation of ventricular arrhythmogenic focus with cardiopulmonary	33261	Prior authorization is required. For additional information please reference Cardiac Ablation Procedure, MP- DE-1187
bypass		-
Endoscopy, surgical; operative tissue ablation and reconstruction of atria, limited	33265	Prior authorization is required. For additional information please reference Cardiac Ablation Procedure, MP- DE-1187
(eg, modified maze procedure), without		·
cardiopulmonary bypass Endoscopy, surgical; operative tissue	33266	Prior authorization is required. For additional information please reference Cardiac Ablation Procedure, MP-
ablation and reconstruction of atria, extensive (eg, maze procedure), without		DE-1187
cardiopulmonary bypass		
Intracardiac electrophysiologic 3-dimensional mapping (List separately in addition to code	93613	Prior authorization is required. For additional information please reference Cardiac Ablation Procedure, MP-
for primary procedure)		DE-1187
Intracardiac catheter ablation of atrioventricular node function, atrioventricular	93650	Prior authorization is required. For additional information please reference Cardiac Ablation Procedure, MP- DE-1187
conduction for creation of complete heart		DE-118/
block, with or without temporary pacemaker placement		
Comprehensive electrophysiologic evaluation	93653	Prior authorization is required. For additional information please reference Cardiac Ablation Procedure, MP-
with insertion and repositioning of multiple electrode catheters, induction or attempted		DE-1187
induction of an arrhythmia with right atrial		
pacing and recording and catheter ablation of arrhythmogenic focus, including intracardiac		
electrophysiologic 3-dimensional mapping,		
right ventricular pacing and recording, left atrial pacing and recording from coronary		
sinus or left atrium, and His bundle recording, when performed; with treatment of		
supraventricular tachycardia by ablation of		
fast or slow atrioventricular pathway, accessory atrioventricular connection, cavo-		
tricuspid isthmus or other single atrial focus		
or source of atrial re-entry		
Comprehensive electrophysiologic evaluation	93654	Prior authorization is required. For additional information please reference Cardiac Ablation Procedure, MP-
Comprehensive electrophysiologic evaluation with insertion and repositioning of multiple	93654	Prior authorization is required. For additional information please reference Cardiac Ablation Procedure, MP- DE-1187
Comprehensive electrophysiologic evaluation with insertion and repositioning of multiple electrode catheters, induction or attempted induction of an arrhythmia with right atrial	93654	
Comprehensive electrophysiologic evaluation with insertion and repositioning of multiple electrode catheters, induction or attempted induction of an arrhythmia with right atrial pacing and recording and catheter ablation of	93654	
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Comprehensive electrophysiologic evaluation with insertion and repositioning of multiple electrode catheters, induction or attempted induction of an arrhythmia with right atrial pacing and recording and catheter ablation of arrhythmogenic focus, including intracardiac	93654	
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Comprehensive electrophysiologic evaluation with insertion and repositioning of multiple electrode catheters, induction or attempted induction of an arrhythmia with right atrial pacing and recording and catheter ablation of arrhythmogenic focus, including intracardiac electrophysiologic 3-dimensional mapping, right ventricular pacing and recording, left atrial pacing and recording from coronary	93654	
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Amorbies per c Q426 Prior authorization is required. For additional information please reference Amniotic Membrane and Amniotic Fluid, MP-0F1194 Prior authorization is required. For additional information please reference Amniotic Membrane and Amniotic Fluid, MP-0F1194 Prior authorization is required. For additional information please reference Amniotic Membrane and Amniotic Fluid, MP-0F1194 Prior authorization is required. For additional information please reference Amniotic Membrane and Amniotic Fluid, MP-0F1194 Prior authorization is required. For additional information please reference Amniotic Membrane and Amniotic Fluid, MP-0F1194 Prior authorization is required. For additional information please reference Amniotic Membrane and Amniotic Fluid, MP-0F1194 Prior authorization is required. For additional information please reference Amniotic Membrane and Amniotic Fluid, MP-0F1194 Prior authorization is required. For additional information please reference Amniotic Membrane and Amniotic Fluid, MP-0F1194 Prior authorization is required. For additional information please reference Amniotic Membrane and Amniotic Fluid, MP-0F1194 Prior authorization is required. For additional information please reference Amniotic Membrane and Amniotic Fluid, MP-0F1194 Prior authorization is required. For additional information please reference Amniotic Membrane and Amniotic Fluid, MP-0F1194 Prior authorization is required. For additional information please reference Amniotic Membrane and Amniotic Fluid, MP-0F1194 Prior authorization is required. For additional information please reference Amniotic Membrane and Amniotic Fluid, MP-0F1194 Prior authorization is required. For additional information please reference Amniotic Membrane and Amniotic Fluid, MP-0F1194 Prior authorization is required. For additional information please reference Amniotic Membrane and Amniotic Fluid, MP-0F1194 Prior authorization is required. For additional information please reference Amniotic Membrane and Amniotic Fluid, MP-0F1194 Prior au	Procenta, per 200 mg	Q4244	Prior authorization is required. For additional information please reference Amniotic Membrane and
Coverset or PorText, per co O2246	AmnioText, per cc	Q4245	
Amniotic Fluid, MP-DE-1194 Prior authorization is required. For additional information please reference Amniotic Membrane and Amniotic Fluid, MP-DE-1194 Amniotic Fluid, MP-DE-1194 Prior authorization is required. For additional information please reference Amniotic Membrane and Amniotic Fluid, MP-DE-1194 Amniotic Flu	CoreText or ProText, per cc	Q4246	
Democryte Armiotic Membrane Allogadf, par 192488 Prior authorization is required. For additional information please reference Armiotic Membrane and Ammiotic Fluid, MP-DE-1194 Prior authorization is required. For additional information please reference Armiotic Membrane and Ammiotic Fluid, MP-DE-1194 Prior authorization is required. For additional information please reference Armiotic Membrane and Ammiotic Fluid, MP-DE-1194 Prior authorization is required. For additional information please reference Armiotic Membrane and Ammiotic Fluid, MP-DE-1194 Prior authorization is required. For additional information please reference Armiotic Membrane and Ammiotic Fluid, MP-DE-1194 Prior authorization is required. For additional information please reference Ammiotic Membrane and Ammiotic Fluid, MP-DE-1194 Prior authorization is required. For additional information please reference Ammiotic Membrane and Ammiotic Fluid, MP-DE-1194 Prior authorization is required. For additional information please reference Ammiotic Membrane and Ammiotic Fluid, MP-DE-1194 Prior authorization is required. For additional information please reference Supervised Exercise Therapy for Peripheral Artery Disease Prior authorization is required. For additional information please reference Supervised Exercise Therapy for Peripheral Artery Disease. Prior authorization is required. For additional information please reference Supervised Exercise Therapy for Authorization Brain promocodinal prior authorization is required. For additional information please reference Temporomandibular Joint Opylanction, MP-DE-1194 Prior authorization is required. For additional information please reference Temporomandibular Joint Opylanction, MP-DE-1196 Prior authorization is required. For additional information please reference Temporomandibular Joint Opylanction, MP-DE-1196 Prior authorization is required. For additional information please reference Temporomandibular Joint Opylanction, MP-DE-1196 Prior authorization is required. For additional information please referen	Amelatavi natah naran am	04247	Amniotic Fluid, MP-DE-1194
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Ammiotic Fluid, MP-DE-1194 Prior authorization is required. For additional information please reference Supervised Exercise Therapy for Peripheral Artery Disease, MP-DE-1196 Prior authorization is required. For additional information please reference Temporomandibular Joint Dysfunction, MP-DE-1196 Prior authorization is required. For additional information please reference Temporomandibular Joint Dysfunction, MP-DE-1196 Prior authorization is required. For additional information please reference Temporomandibular Joint Dysfunction, MP-DE-1196 Prior authorization is required. For additional information please reference Temporomandibular Joint Dysfunction, MP-DE-1196 Prior authorization is required. For additional information please reference Temporomandibular Joint Dysfunction, MP-DE-1196 Prior au		Q4248	
Armolochy MP, per sq cm 04256 Prior authorization is required. For additional information please reference Amniotic Membrane and Amniotic Plaid, MP-DE-1136 Prior authorization is required. For additional information please reference Amniotic Membrane and Amniotic Plaid, MP-DE-1136 Prior authorization is required. For additional information please reference Amniotic Membrane and Amniotic Plaid, MP-DE-1136 Prior authorization is required. For additional information please reference Amniotic Membrane and Amniotic Plaid, MP-DE-1136 Prior authorization is required. For additional information please reference Amniotic Membrane and Amniotic Plaid, MP-DE-1136 Prior authorization is required. For additional information please reference Amniotic Membrane and Amniotic Plaid, MP-DE-1136 Prior authorization is required. For additional information please reference Supervised Exercise Therapy for Petipheral Artery Disease. MP-DE-1013 Prior authorization is required. For additional information please reference Supervised Exercise Therapy for Petipheral Artery Disease. MP-DE-1013 Prior authorization is required. For additional information please reference Supervised Exercise Therapy for Petipheral Artery Disease. MP-DE-1013 Prior authorization Requirement of Improvementational prettip. Prior authorization is required. For additional information please reference Temporomandibular Joint Dysfunction, MP-DE-1136 Prior authorization is required. For additional information please reference Temporomandibular Joint Dysfunction, MP-DE-1136 Prior authorization is required. For additional information please reference Temporomandibular Joint Dysfunction, MP-DE-1136 Prior authorization is required. For additional information please reference Temporomandibular Joint Dysfunction, MP-DE-1136 Prior authorization is required. For	AMNIPLY, for topical use only, per sq cm	Q4249	
Novarian C.D., per sq cm	AmnioAmp-MP, per sq cm	Q4250	Prior authorization is required. For additional information please reference Amniotic Membrane and
Prior authorization is required. For additional information please reference Amniotic Membrane and Amniotic Fluid, MP-DE-1194 Amniotic Fluid, MP-DE-1194 Prior authorization is required. For additional information please reference Amniotic Membrane and Amniotic Fluid, MP-DE-1194 Prior authorization is required. For additional information please reference Amniotic Membrane and Amniotic Fluid, MP-DE-1194 Prior authorization is required. For additional information please reference Amniotic Membrane and Amniotic Fluid, MP-DE-1194 Prior authorization is required. For additional information please reference Supervised Exercise Therapy for retabilitation, per session Peripheral Artery Disease, MP-DE-1013 Prior authorization is required. For additional information please reference Emporomandibular biolity (Prior authorization is required. For additional information please reference Temporomandibular service (e., general or monitored anesthesia service) (e., general service	Novafix DL, per sq cm	Q4254	
Amniotic Fluid, MP-DE-1194 Prior authorization is required. For additional information please reference Amniotic Membrane and Amniotic Fluid, MP-DE-1194 Prior Authorization Requirement Peripheral Attery Disease Prior Authorization Requirement Prior Authorization Prior Authoriza	REGUARD, for topical use only, per sq cm	O4255	·
Amniotic Fluid, MP-DE-1194			Amniotic Fluid, MP-DE-1194
Peripheral Artery Disease Prior authorization is required. For additional information please reference Supervised Exercise Therapy for Peripheral Artery Diseases, MP-DE-1013 Peripheral Artery Diseases, MP-DE-1013 Prior authorization Requirement Manipulation of the propromandibular joint(s) [XIII.) therapoutic, requiring an anesthesia service (i.e., general or monitored anesthesia service) proprietation is required. For additional information please reference Temporomandibular joint by function, MP-DE-1136 Prior authorization is required. For additional information please reference Temporomandibular joint proprietation and information please reference Temporomandibular joi	reconstruction, per procedure		Amniotic Fluid, MP-DE-1194
Peripheral ateries disease (PAD) Peripheral retried disease (PAD) Peripheral Artery Disease, MP-DE-1013 Prior authorization is required. For additional information please reference Supervised Exercise Therapy for Peripheral Artery Disease, MP-DE-1013 Prior Authorization is required. For additional information please reference Temporomandibular Joint Dysfunction, MP-DE-1136 Desed treatment of temporomandibular dislocation, initial or authorization is required. For additional information please reference Temporomandibular Joint Dysfunction, MP-DE-1136 Desed treatment of temporomandibular dislocation, initial or authorization is required. For additional information please reference Temporomandibular Joint Dysfunction, MP-DE-1136 Desed treatment of temporomandibular dislocation, or pilling, plant or subsequent Desed treatment of temporomandibular dislocation, or pilling, plant or subsequent Desed treatment of temporomandibular dislocation or splinting, plant or subsequent Department of temporomandibular plant Dysfunction, MP-DE-1136 Desed treatment Dysfunct	Supervised Exercise Therapy for Peripheral Artery Disease	Codes	Prior Authorization Requirement
Prior Authorization Requirement	Peripheral arterial disease (PAD)	93668	
(TMJ), therapeutic, requiring an anesthesia service (ie, general or monitored anesthesia service (ie), general or monitored (i			Prior Authorization Requirement
Dysfunction, MP-DE-1136	Manipulation of temporomandibular joint(s) (TMJ), therapeutic, requiring an anesthesia service (ie, general or monitored anesthesia care)	21073	
Dosed treatment of temporomandibular dislocation; complicated (eg., recurrent equiring intermaxillary fixation or splinting), initial or authorization is required. For additional information please reference Temporomandibular Joint Dysfunction, MP-DE-1136 Prior authorization is required. For additional information please reference Temporomandibular Joint Dysfunction, MP-DE-1136 Prior authorization is required. For additional information please reference Temporomandibular Joint Dysfunction, MP-DE-1136 Prior authorization is required. For additional information please reference Temporomandibular Joint Dysfunction, MP-DE-1136 Prior authorization is required. For additional information please reference Temporomandibular Joint Dysfunction, MP-DE-1136 Prior authorization is required. For additional information please reference Temporomandibular Joint Dysfunction, MP-DE-1136 Prior authorization is required. For additional information please reference Temporomandibular Joint Dysfunction, MP-DE-1136 Prior authorization is required. For additional information please reference Temporomandibular Joint Dysfunction, MP-DE-1136 Prior authorization is required. For additional information please reference Temporomandibular Joint Dysfunction, MP-DE-1136 Prior authorization is required. For additional information please reference Temporomandibular Joint Dysfunction, MP-DE-1136 Prior authorization is required. For additional information please reference Temporomandibular Joint Dysfunction, MP-DE-1136 Prior authorization is required. For additional information please reference Temporomandibular Joint Dysfunction, MP-DE-1136 Prior authorization is required. For additional information please reference Temporomandibular Joint Dysfunction, MP-DE-1136 Prior authorization is required. For additional information please reference Temporomandibular Joint Dysfunction, MP-DE-1136 Prior authorization is required. For additional information please reference Temporomandibular Joint Dysfunction, MP-DE-1136 Prior authorization is re	Closed treatment of temporomandibular dislocation; initial or subsequent	21480	
requiring intermaxillary fixation or splinting), initial or subsequent Open treatment of temporomandibular dislocation Opysfunction, MP-DE-1136 Open treatment of temporomandibular joint, Dysfunction, MP-DE-1136 Open treatment of temporomandibular joint, Dysfunction, MP-DE-1136 Open treatment of without synovial biopsy (separate procedure) Opysfunction, MP-DE-1136 Opysfunction, MP-DE-1136 Opphhalmic, maxillary, mandibular joint attrography, radiological supervision and interpretation Opysfunction, MP-DE-1136 Opysfunction, MP-DE-1136 Opysfunction, MP-DE-1136 Opphhalmic, protony imaging, control prease reference Temporomandibular Joint Opysfunction, MP-DE-1136 Opysfunction, MP-DE-1136 Opphhalmic, protony imaging, control prease reference Temporomandibular Joint Opysfunction, MP-DE-1136 Opphhalmic, protony imaging, control prease reference Temporomandibular Joint Opysfunction, MP-DE-1136 Opphhalmic, protony imaging, control prease reference Temporomandibular Joint Opysfunction, MP-DE-1136 Opphhalmic, protony imaging, control prease reference Temporomandibular Joint Opysfunction, MP-DE-1136 Opphhalmic, protony imaging, control prease reference Temporomandibular Joint Opysfunction, MP-DE-1136 Opphhalmic, protony imaging, control prease reference Temporomandibular Joint Opysfunction, MP-DE-1136 Opphhalmic, protony imaging, control prease reference Temporomandibular Joint Opysfunction, MP-DE-1136 Opphhalmic, protony imaging, control prease refer		21485	Prior authorization is required. For additional information please reference Temporomandibular Joint
Dean treatment of temporomandibular dislocation Dysfunction, MP-DE-1136 Arthroscopy, temporomandibular joint, diagnostic, with or without synovial biopsy separate procedure) Arthroscopy, temporomandibular joint, diagnostic, with or without synovial biopsy separate procedure) Arthroscopy, temporomandibular joint, bysfunction, MP-DE-1136 Separate procedure) Arthroscopy, temporomandibular joint, bysfunction, MP-DE-1136 Prior authorization is required. For additional information please reference Temporomandibular Joint bysfunction, MP-DE-1136 Injection(s), anesthetic agent(s) and/or steroic tingential neve, each branch (e. potential never) prior authorization is required. For additional information please reference Temporomandibular Joint pysfunction, MP-DE-1136 Caphalogram, orthodontic Orthopantogram (e. panoramic x-ray) Orthopantogram (e. panoramic x-ray) 70355 Prior authorization is required. For additional information please reference Temporomandibular Joint pysfunction, MP-DE-1136 Computed tomography, maxillofacial area; Whoul contrast material	requiring intermaxillary fixation or splinting),		Dystunction, MP-DE-1136
Arthroscopy, temporomandibular joint, diagnostic, with or without synovial biopsy (separate procedure) 29800 Prior authorization is required. For additional information please reference Temporomandibular Joint Dysfunction, MP-DE-1136 Prior authorization is required. For additional information please reference Temporomandibular Joint Dysfunction, MP-DE-1136 Prior authorization is required. For additional information please reference Temporomandibular Joint Dysfunction, MP-DE-1136 Prior authorization is required. For additional information please reference Temporomandibular Joint Dysfunction, MP-DE-1136 Prior authorization is required. For additional information please reference Temporomandibular Joint Dysfunction, MP-DE-1136 Prior authorization is required. For additional information please reference Temporomandibular Joint Dysfunction, MP-DE-1136 Prior authorization is required. For additional information please reference Temporomandibular Joint Dysfunction, MP-DE-1136 Prior authorization is required. For additional information please reference Temporomandibular Joint Dysfunction, MP-DE-1136 Prior authorization is required. For additional information please reference Temporomandibular Joint Dysfunction, MP-DE-1136 Prior authorization is required. For additional information please reference Temporomandibular Joint Dysfunction, MP-DE-1136 Prior authorization is required. For additional information please reference Temporomandibular Joint Dysfunction, MP-DE-1136 Prior authorization is required. For additional information please reference Temporomandibular Joint Dysfunction, MP-DE-1136 Prior authorization is required. For additional information please reference Temporomandibular Joint Dysfunction, MP-DE-1136 Prior authorization is required. For additional information please reference Temporomandibular Joint Dysfunction, MP-DE-1136		21490	
Separate procedure	Arthroscopy, temporomandibular joint,	29800	Prior authorization is required. For additional information please reference Temporomandibular Joint
Surgical Dysfunction, MP-DE-1136	diagnostic, with or without synovial biopsy (separate procedure)		
Steroid: tignement nerve, each branch (ie, ophthalmic, maxillary, mandibular) Prior authorization is required. For additional information please reference Temporomandibular Joint arthorography, and interpretation Magnetic resonance (e.g. proton) imaging, temporomandibular Joint opysfunction, MP-DE-1136 Prior authorization is required. For additional information please reference Temporomandibular Joint opysfunction, MP-DE-1136 Prior authorization is required. For additional information please reference Temporomandibular Joint opysfunction, MP-DE-1136 Prior authorization is required. For additional information please reference Temporomandibular Joint opysfunction, MP-DE-1136 Prior authorization is required. For additional information please reference Temporomandibular Joint opysfunction, MP-DE-1136 Prior authorization is required. For additional information please reference Temporomandibular Joint opysfunction, MP-DE-1136 Prior authorization is required. For additional information please reference Temporomandibular Joint opysfunction, MP-DE-1136 Prior authorization is required. For additional information please reference Temporomandibular Joint opysfunction, MP-DE-1136	surgical		Dysfunction, MP-DE-1136
pophthalmic, maxillary, mandibular) 70332 Prior authorization is required. For additional information please reference Temporomandibular Joint Dysfunction, MP-DE-1136 Prior authorization is required. For additional information please reference Temporomandibular Joint Dysfunction, MP-DE-1136 Prior authorization is required. For additional information please reference Temporomandibular Joint Dysfunction, MP-DE-1136 Cephalogram, orthodontic Orthopantogram (eg. panoranic x-ray) 70350 Prior authorization is required. For additional information please reference Temporomandibular Joint Dysfunction, MP-DE-1136 Orthopantogram (eg. panoranic x-ray) 70355 Prior authorization is required. For additional information please reference Temporomandibular Joint Dysfunction, MP-DE-1136 Computed tomography, maxilofacial area; without contrast material 70486 Prior authorization is required. For additional information please reference Temporomandibular Joint Dysfunction, MP-DE-1136	steroid; trigeminal nerve, each branch (ie,	64400	
Dysfunction, MP-DE-1136 Magnetic resonance (eg. proton) imaging. Prior authorization is required. For additional information please reference Temporomandibular Joint Dysfunction, MP-DE-1136 Caphalogram, orthodontic Prior authorization is required. For additional information please reference Temporomandibular Joint Dysfunction, MP-DE-1136 Orthopanlogram (eg. panoranic x-ray) Prior authorization is required. For additional information please reference Temporomandibular Joint Dysfunction, MP-DE-1136 Orthopanlogram (eg. panoranic x-ray) Prior authorization is required. For additional information please reference Temporomandibular Joint Dysfunction, MP-DE-1136 Orthopanlogram (eg. panoranic x-ray) Prior authorization is required. For additional information please reference Temporomandibular Joint Dysfunction, MP-DE-1136		70332	
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Orthopantogram (eg., panoramic x-ray) 70355 Prior authorization is required. For additional information please reference Temporomandibular Joint Dysfunction, MP-DE-1136 Computed tomography, maxillofacial area; without contrast material 70486 Prior authorization is required. For additional information please reference Temporomandibular Joint Dysfunction, MP-DE-1136	temporomandibular joint(s)		Dysfunction, MP-DE-1136
Dysfunction, MP-DE-1136 Computed tomography, maxillofacial area: 70486 Prior authorization cylinder, For additional information please reference Temporomandibular Joint Dysfunction, MP-DE-1136	Cepnalogram, orthodontic	/0350	
Computed tomography, maxillofacial area; 70486 Prior authorization is required. For additional information please reference Temporomandibular Joint Dysfunction, MP-DE-1136	Orthopantogram (eg, panoramic x-ray)	70355	
5) State (101) 111 52 1130		70486	Prior authorization is required. For additional information please reference Temporomandibular Joint
Computed tomography, maxillofacial area; 70487 Prior authorization is required. For additional information please reference Temporomandibular Joint		70487	
with contrast material(s) Dysfunction, MP-DE-1136			
Assistance transfer, followed by Dysfunction, MP-DE-1136 Dysfunction, MP-DE-1136	with contrast material(s)		Dysfunction, MP-DE-1136

Unlisted physical medicine/rehabilitation	97799	Prior authorization is required. For additional information please reference Temporomandibular Initia
service or procedure		Prior authorization is required. For additional information please reference Temporomandibular Joint Dysfunction, MP-DE-1136
Transcutaneous electrical nerve stimulation (TENS) device, two-lead, localized stimulation	E0720	Prior authorization is required for billed charges greater than \$500. For additional information please reference Temporomandibular Joint Dysfunction, MP-DE-1136
Transcutaneous electrical nerve stimulation (TENS) device, four or more leads, for multiple nerve stimulation	E0730	Prior authorization is required for billed charges greater than \$500. For additional information please reference Temporomandibular Joint Dysfunction, MP-DE-1136
X-ray of skull, fewer than 4 views	70250	Prior authorization is required. For additional information please reference Temporomandibular Joint Dysfunction, MP-DE-1136
Radiologic examination, skull; complete, minimum of 4 views	70260	Prior authorization is required. For additional information please reference Temporomandibular Joint Dysfunction, MP-DE-1136
Ultrasound, soft tissues of head and neck (eg, thyroid, parathyroid, parotid), real time with image documentation	76536	Prior authorization is required. For additional information please reference Temporomandibular Joint Dysfunction, MP-DE-1136
Bone and/or joint imaging; limited area	78300	Prior authorization is required. For additional information please reference Temporomandibular Joint Dysfunction, MP-DE-1136
Bone and/or joint imaging; multiple areas Needle electromyography; cranial nerve	78305 95867	Prior authorization is required. For additional information please reference Temporomandibular Joint Dysfunction, MP-DE-1136
supplied muscle(s), unilateral Needle electromyography; cranial nerve	95868	Prior authorization is required. For additional information please reference Temporomandibular Joint Dysfunction, MP-DE-1136 Prior authorization is required. For additional information please reference Temporomandibular Joint
supplied muscles, bilateral		Dysfunction, MP-DE-1136
Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper limbs	95925	Prior authorization is required. For additional information please reference Temporomandibular Joint Dysfunction, MP-DE-1136
Neuromuscular junction testing (repetitive stimulation, paired stimuli), each nerve, any 1 method	95937	Prior authorization is required. For additional information please reference Temporomandibular Joint Dysfunction, MP-DE-1136
Application of a modality to 1 or more areas; iontophoresis, each 15 minutes	97033	Prior authorization is required. For additional information please reference Temporomandibular Joint Dysfunction, MP-DE-1136
Therapeutic procedure, 1 or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)	97124	Prior authorization is required. For additional information please reference Temporomandibular Joint Dysfunction, MP-DE-1136
Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes	97140	Prior authorization is required. For additional information please reference Temporomandibular Joint Dysfunction, MP-DE-1136
Wearable Cardioverter-Defibrillator Interrogation device evaluation (in person)	Codes 93292	Prior Authorization Requirement Prior authorization is required. For additional information please reference Wearable Cardioverter-
with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; wearable defibrillator system	33232	Defibrillator, MP-DE-1138
Initial set-up and programming by a physician or other qualified health care professional of wearable cardioverter-defibilitator includes initial programming of system, establishing baseline electronic ECG, transmission of data to data repository, patient instruction in wearing system and patient reporting of problems or events	93745	Prior authorization is required. For additional information please reference Wearable Cardioverter- Defibrillator, MP-DE-1138
Automatic external defibrillator, with integrated electrocardiogram analysis, garment type	K0606	Prior authorization is required for billed charges greater than \$500. For additional information please reference Wearable Cardioverter-Defibrillator, MP-DE-1138
Heart-lung Transplant Heart-lung transplant with recipient	33935	Prior Authorization Requirement Prior authorization is required. For additional information please reference Heart/Lung Transplant, MP-DE-
Heart-lung transplant with recipient cardiectomy-pneumonectomy Intra-Arterial/Intravenous Therapeutic		
Heart-lung transplant with recipient cardiectomy-pneumonectomy Intra-Arterial/intravenous Therapeutic Procedures Introduction of needle(s) and/or catheter(s),	33935	Prior authorization is required. For additional information please reference Heart/Lung Transplant, MP-DE- 1108 Prior Authorization Requirement Prior authorization is required. For additional information please reference Intra-Arterial/Intravenous
Heart-lung transplant with recipient cardiectomy-pneumonectomy Intra-Arterial/Intravenous Therapeutic Procedures	33935 Codes	Prior authorization is required. For additional information please reference Heart/Lung Transplant, MP-DE- 1108 Prior Authorization Requirement
ibart-lung transplant with recipient cardiectomy-pneumonectomy intra-Arterial/Intravenous Therapeutic Procedures Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contrast, all necessary inaging from the arterial anastomosis and adjacent antery through entire venous outflow including the Inferior or superior vena cava, fluoroscopic judiance, radiological supervision and interpretation and image documentation and report: Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of cortinast, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous cultive including the inferior or supenor vena cava, fluoroscopic guidance, radiological supervision and interpretation and image documentation and report: with transluminal balloon angiopiasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty	33935 Codes 36901	Prior authorization is required. For additional information please reference Heart/Lung Transplant, MP-DE- 1108 Prior Authorization is required. For additional information please reference Intra-Arterial/Intravenous Therapeutic Procedures, MP-DE-1109 Prior authorization is required. For additional information please reference Intra-Arterial/Intravenous Therapeutic Procedures, MP-DE-1109
Heart-lung transplant with recipient cardiectomy-pneumonectomy Intra-Arterial/Intravenous Therapeutic Procedures Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contrast, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous cultivo including the inferior or superior vena cava, fluoroscopic guidance, radiological supervision and interpretation and image documentation and report; Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit, procluding all interpretation and image documentation and report; undertine venue control interpretation and image documentation and report; with transluminal balicon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation	33935 Codes 36901	Prior authorization is required. For additional information please reference Heart/Lung Transplant, MP-DE- 1108 Prior Authorization Requirement Prior authorization is required. For additional information please reference Intra-Arterial/Intravenous Therapeutic Procedures, MP-DE-1109 Prior authorization is required. For additional information please reference Intra-Arterial/Intravenous

Percutaneous transluminal mechanical thrombectory and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural	36905	Prior authorization is required. For additional information please reference Intra-Arterial/Intravenous Therapeutic Procedures, MP-DE-1109
pharmacological thrombolytic injection(s); with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty		
Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological	36906	Prior authorization is required. For additional information please reference Intra-Arterial/Intravenous Therapeutic Procedures, MP-DE-1109
supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to		
perform the stenting, and all angioplasty within the peripheral dialysis circuit	25007	
Transluminal balloon angioplasty, central dialysis segment, performed through dialysis circuit, including all imaging and radiological supervision and interpretation required to perform the angioplasty (List separately in addition to code for primary procedure)	36907	Prior authorization is required. For additional information please reference Intra-Arterial/Intravenous Therapeutic Procedures, MP-DE-1109
Transcatheter placement of intravascular stent(s), central diays is segment, performed through dialysis circuit, including all imaging and radiological supervision and interpretation required to perform the stenting, and all angioplasty in the central dialysis segment (List separately in addition to code for primary procedure)	36908	Prior authorization is required. For additional information please reference Intra-Arterial/Intravenous Therapeutic Procedures, MP-DE-1109
Dalysis circuit permanent vascular embolization or occlusion (including main circuit or any accessory veins), endovascular, including all imaging and radiological supervision and interpretation necessary to complete the intervention (List separately in addition to code for primary procedure)	36909	Prior authorization is required. For additional information please reference Intra-Arterial/Intravenous Therapeutic Procedures, MP-DE-1109
Transcatheter therapy, arterial infusion for thrombolysis other than coronary or intracranial, any method, including radiological supervision and interpretation, initial treatment day	37211	Prior authorization is required. For additional information please reference Intra-Arterial/Intravenous Therapeutic Procedures, MP-DE-1109
Transcatheter therapy, venous infusion for thrombolysis, any method, including radiological supervision and interpretation, initial treatment day	37212	Prior authorization is required. For additional information please reference intra-Arterial/Intravenous Therapeutic Procedures, MP-DE-1109
Transcatheter therapy, arterial or venous infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, continued treatment on subsequent day during course of thrombolytic therapy, including follow-up catheter contrast injection, position change, or exchange, when	37213	Prior authorization is required. For additional information please reference Intra-Arterial/Intravenous Therapeutic Procedures, MP-DE-1109
performed; Transcatheter therapy, arterial or venous	37214	Prior authorization is required. For additional information please reference Intra-Arterial/Intravenous
infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, continued treatment on subsequent day during course of thrombolytic therapy, including follow-up catheter contrast injection, position change, or exchange, when performed; cessation of thrombolysis including removal of catheter and vessel		Therapeutic Procedures, MP-DE-1109
closure by any method Transcatheter placement of an intravascular	37236	
stent(s) (except lower extremity artery(s) for occlusive disease, cervical carotid, extracranial vertebral or intrathoracic carotid, intracranial, or coronary), open or percutaneous, including radiological supervision and interpretation and including all angioplasty within the same vessel, when	37236	Prior authorization is required. For additional information please reference Intra-Arterial/Intravenous Therapeutic Procedures, MP-DE-1109
performed; initial artery Transcatheter placement of an intravascular stent(s) (except lower extremity artery(s) for occlusive disease, cervical carotid, extracranial vertebral or intrathoracic carotid.	37237	Prior authorization is required. For additional information please reference Intra-Arterial/Intravenous Therapeutic Procedures, MP-DE-1109
intracranial, or coronary), open or percutaneous, including radiological supervision and interpretation and including all angioplasty within the same vessel, when performed; each additional artery (List separately in addition to code for primary		
procedure) Transcatheter placement of an intravascular stent(s), open or percutaneous, including radiological supervision and interpretation and including angiopasty within the same vessel, when performed; initial vein	37238	Prior authorization is required. For additional information please reference Intra-Arterial/Intravenous Therapeutic Procedures, MP-DE-1109
	37239	Prior authorization is required. For additional information please reference Intra-Arterial/Intravenous Therapeutic Procedures, MP-DE-1109
Transluminal balloon angioplasty (except lower extremity artery(les) for occlusive disease, intracranial, coronary, pulmonary, or dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same artery; initial artery	37246	Prior authorization is required. For additional information please reference Intra-Arterial/Intravenous Therapeutic Procedures, MP-DE-1109

Transluminal balloon angioplasty (except lower extremity artery(ies) for occlusive	37247	Prior authorization is required. For additional information please reference Intra-Arterial/Intravenous
disease, intracranial, coronary, pulmonary, or		Therapeutic Procedures, MP-DE-1109
dialysis circuit), open or percutaneous, including all imaging and radiological		
supervision and interpretation necessary to perform the angioplasty within the same		
artery; each additional artery (List separately		
in addition to code for primary procedure)		
Transluminal balloon angioplasty (except dialysis circuit), open or percutaneous,	37248	Prior authorization is required. For additional information please reference Intra-Arterial/Intravenous Therapeutic Procedures, MP-DE-1109
including all imaging and radiological		interapeutic Procedures, MP-02-1109
supervision and interpretation necessary to perform the angioplasty within the same vein;		
initial vein Transluminal balloon angioplasty (except	37249	Prior authorization is required. For additional information please reference Intra-Arterial/Intravenous
dialysis circuit), open or percutaneous, including all imaging and radiological		Therapeutic Procedures, MP-DE-1109
supervision and interpretation necessary to		
perform the angioplasty within the same vein; each additional vein (List separately in		
addition to code for primary procedure) Percutaneous transluminal pulmonary artery	92997	Driver the single in the singl
balloon angioplasty; single vessel	92997	Prior authorization is required. For additional information please reference Intra-Arterial/Intravenous Therapeutic Procedures, MP-DE-1109
Percutaneous transluminal pulmonary artery balloon angioplasty; each additional vessel	92998	Prior authorization is required. For additional information please reference Intra-Arterial/Intravenous
(List separately in addition to code for		Therapeutic Procedures, MP-DE-1109
primary procedure) Catheter, transluminal angioplasty, nonlaser	C1725	Prior authorization is required. For additional information please reference Intra-Arterial/Intravenous
(may include guidance, infusion/perfusion capability)		Therapeutic Procedures, MP-DE-1109
Stent, coated/covered, with delivery system	C1874	Prior authorization is required. For additional information please reference Intra-Arterial/Intravenous
Stent, noncoated/noncovered, with delivery	C1876	Therapeutic Procedures, MP-DE-1109 Prior authorization is required. For additional information please reference Intra-Arterial/Intravenous
system		Therapeutic Procedures, MP-DE-1109
Catheter, transluminal angioplasty, laser	C1885	Prior authorization is required. For additional information please reference Intra-Arterial/Intravenous
Stent, noncoronary, temporary, with delivery	C2625	Therapeutic Procedures, MP-DE-1109 Prior authorization is required. For additional information please reference Intra-Arterial/Intravenous
system		Therapeutic Procedures, MP-DE-1109
Upper Gastrointestinal Endoscopy (EGD) Esophagogastroduodenoscopy, flexible,	Codes 43235	Prior Authorization Requirement
transoral; diagnostic, including collection of	43235	Prior authorization is required. For additional information please reference Upper Gastrointestinal Endoscopy (EGD), MP-DE-1217
specimen(s) by brushing or washing, when performed (separate procedure)		
Esophagogastroduodenoscopy, flexible, transoral: with directed submucosal	43236	Prior authorization is required. For additional information please reference Upper Gastrointestinal
injection(s), any substance		Endoscopy (EGD), MP-DE-1217
Esophagogastroduodenoscopy, flexible, transoral; with endoscopic ultrasound	43237	Prior authorization is required. For additional information please reference Upper Gastrointestinal Endoscopy (EGD), MP-DE-1217
examination limited to the esophagus, stomach or duodenum, and adjacent		
structures		
Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-	43238	Prior authorization is required. For additional information please reference Upper Gastrointestinal Endoscopy (EGD), MP-DE-1217
guided intramural or transmural fine needle aspiration/biopsy(s), (includes endoscopic		
ultrasound examination limited to the		
esophagus, stomach or duodenum, and adjacent structures)		
Esophagogastroduodenoscopy, flexible, transoral; with biopsy, single or multiple	43239	Prior authorization is required. For additional information please reference Upper Gastrointestinal Endoscopy (EGD), MP-DE-1217
Esophagogastroduodenoscopy, flexible,	43240	Prior authorization is required. For additional information please reference Upper Gastrointestinal
transoral; with transmural drainage of pseudocyst (includes placement of		Endoscopy (EGD), MP-DE-1217
transmural drainage catheter[s]/stent[s],		
when performed, and endoscopic ultrasound, when performed)		
Esophagogastroduodenoscopy, flexible, transoral; with insertion of intraluminal tube or	43241	Prior authorization is required. For additional information please reference Upper Gastrointestinal Endoscopy (EGD), MP-DE-1217
catheter Esophagogastroduodenoscopy, flexible,	43242	Prior authorization is required. For additional information please reference Upper Gastrointestinal
transoral; with transendoscopic ultrasound-	43242	Endoscopy (EGD), MP-DE-1217
guided intramural or transmural fine needle aspiration/biopsy(s) (includes endoscopic		
ultrasound examination of the esophagus, stomach, and either the duodenum or a		
surgically altered stomach where the jejunum		
is examined distal to the anastomosis)		
Esophagogastroduodenoscopy, flexible, transoral; with injection sclerosis of	43243	Prior authorization is required. For additional information please reference Upper Gastrointestinal Endoscopy (EGD), MP-DE-1217
esophageal/gastric varices Esophagogastroduodenoscopy, flexible,	43244	Prior authorization is required. For additional information please reference Upper Gastrointestinal
transoral; with band ligation of	43244	Endoscopy (EGD), MP-DE-1217
esophageal/gastric varices Esophagogastroduodenoscopy, flexible,	43245	Prior authorization is required. For additional information please reference Upper Gastrointestinal
transoral; with dilation of gastric/duodenal stricture(s) (eg, balloon, bougie)		Endoscopy (EGD), MP-DE-1217
Esophagogastroduodenoscopy, flexible,	43246	Prior authorization is required. For additional information please reference Upper Gastrointestinal
transoral; with directed placement of percutaneous gastrostomy tube		Endoscopy (EGD), MP-DE-1217
Esophagogastroduodenoscopy, flexible, transoral; with removal of foreign body(s)	43247	Prior authorization is required. For additional information please reference Upper Gastrointestinal Endoscopy (EGD), MP-DE-1217
Esophagogastroduodenoscopy, flexible,	43248	Prior authorization is required. For additional information please reference Upper Gastrointestinal
transoral; with insertion of guide wire followed by passage of dilator(s) through esophagus		Endoscopy (EGD), MP-DE-1217
over guide wire	42240	Drier authorization is convived. For additional information also are supported by
Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic balloon	43249	Prior authorization is required. For additional information please reference Upper Gastrointestinal Endoscopy (EGD), MP-DE-1217
dilation of esophagus (less than 30 mm diameter)		
Esophagogastroduodenoscopy, flexible, transoral; with removal of tumor(s), polyp(s),	43250	Prior authorization is required. For additional information please reference Upper Gastrointestinal
or other lesion(s) by hot biopsy forceps	42274	Endoscopy (EGD), MP-DE-1217
Esophagogastroduodenoscopy, flexible, transoral; with removal of tumor(s), polyp(s),	43251	Prior authorization is required. For additional information please reference Upper Gastrointestinal Endoscopy (EGD), MP-DE-1217
or other lesion(s) by snare technique Esophagogastroduodenoscopy, flexible,	43252	Prior authorization is required. For additional information please reference Upper Gastrointestinal
transoral; with optical endomicroscopy		Endoscopy (EGD), MP-DE-1217
Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-	43253	Prior authorization is required. For additional information please reference Upper Gastrointestinal
guided transmural injection of diagnostic or		Endoscopy (EGD), MP-DE-1217
therapeutic substance(s) (eg, anesthetic, neurolytic agent) or fiducial marker(s)		
(includes endoscopic ultrasound examination of the esophagus, stomach, and either the		
duodenum or a surgically altered stomach		
where the jejunum is examined distal to the anastomosis)		

Esophagogastroduodenoscopy, flexible,	43254	Prior authorization is required. For additional information please reference Upper Gastrointestinal
transoral; with endoscopic mucosal resection		Endoscopy (EGD), MP-DE-1217
Esophagogastroduodenoscopy, flexible, transoral; with control of bleeding, any method	43255	Prior authorization is required. For additional information please reference Upper Gastrointestinal Endoscopy (EGD), MP-DE-1217
Esophagogastroduodenoscopy, flexible, transoral; with delivery of thermal energy to the muscle of lower esophageal sphincter and/or gastric cardia, for treatment of gastroesophageal reflux disease	43257	Prior authorization is required. For additional information please reference Upper Gastrointestinal Endoscopy (EGD), MP-DE-1217
Esophagogastroduodenoscopy, flexible, transoral; with endoscopic ultrasound examination, including the esophagus, stomach, and either the duodenum or a surgically altered stomach where the jejunum is examined distal to the anastomosis	43259	Prior authorization is required. For additional information please reference Upper Gastrointestinal Endoscopy (EGD), MP-DE-1217
Endoscopic retrograde cholangiopancreatography (ERCP); diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	43260	Prior authorization is required. For additional information please reference Upper Gastrointestinal Endoscopy (EGD), MP-DE-1217
Endoscopic retrograde cholangiopancreatography (ERCP); with biopsy, single or multiple	43261	Prior authorization is required. For additional information please reference Upper Gastrointestinal Endoscopy (EGD), MP-DE-1217
Endoscopic retrograde cholangiopancreatography (ERCP); with sphincterotomy/papillotomy	43262	Prior authorization is required. For additional information please reference Upper Gastrointestinal Endoscopy (EGD), MP-DE-1217
Endoscopic retrograde cholangiopancreatography (ERCP); with pressure measurement of sphincter of Oddi	43263	Prior authorization is required. For additional information please reference Upper Gastrointestinal Endoscopy (EGD), MP-DE-1217
Endoscopic retrograde cholangiopancreatography (ERCP); with removal of calculi/debris from biliary/pancreatic duct(s)	43264	Prior authorization is required. For additional information please reference Upper Gastrointestinal Endoscopy (EGD), MP-DE-1217
Endoscopic retrograde cholangiopancreatography (ERCP); with destruction of calculi, any method (eg, mechanical, electrohydraulic, lithotripsy)	43265	Prior authorization is required. For additional information please reference Upper Gastrointestinal Endoscopy (EGD), MP-DE-1217
Esophagogastroduodenoscopy, flexible, transoral; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)	43266	Prior authorization is required. For additional information please reference Upper Gastrointestinal Endoscopy (EGD), MP-DE-1217
Esophagogastroduodenoscopy, flexible, transoral; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post- dilation and guide wire passage, when performed)	43270	Prior authorization is required. For additional information please reference Upper Gastrointestinal Endoscopy (EGD), MP-DE-1217
Endoscopic retrograde cholangiopancreatography (ERCP); with placement of endoscopic stent into biliary or pancreatic duct, including pre- and post- dilation and guide wire passage, when performed, including sphincterotomy, when performed, each stent	43274	Prior authorization is required. For additional information please reference Upper Gastrointestinal Endoscopy (EGD), MP-DE-1217
Endoscopic retrograde cholangiopancreatography (ERCP); with removal of foreign body(s) or stent(s) from biliary/pancreatic duct(s)	43275	Prior authorization is required. For additional information please reference Upper Gastrointestinal Endoscopy (EGD), MP-DE-1217
Endoscopic retrograde cholangiopancreatography (ERCP); with removal and exchange of stent(s), biliary or pancreatic duct, including pre- and post- dilation and guide wire passage, when performed, including sphincterotomy, when performed, each stent exchanged	43276	Prior authorization is required. For additional information please reference Upper Gastrointestinal Endoscopy (EGD), MP-DE-1217
Endoscopic retrograde cholangiopancreatography (ERCP); with trans-endoscopic balloon dilation of biliary/pancreatic duct(s) or of ampulla (sphincteroplasty), including sphincterotomy, when performed, each duct	43277	Prior authorization is required. For additional information please reference Upper Gastrointestinal Endoscopy (EGD), MP-DE-1217
Endoscopic retrograde cholangiopancreatography (ERCP); with ablation of tumor(s), polyp(s), or other lesion(s), including pre- and post-dilation and guide wire passage, when performed	43278	Prior authorization is required. For additional information please reference Upper Gastrointestinal Endoscopy (EGD), MP-DE-1217
Anthrax Bovine Collagen Arthroscopy, shoulder, surgical; with rotator	29827	Prior Authorization Requirement Prior authorization is required. For additional information please reference Anthrax Bovine Collagen, MP-DE-
cuff repair Unlisted procedure, arthroscopy	29999	1223 Prior authorization is required. For additional information please reference Anthrax Bovine Collagen, MP-DE-
BRCA1 & BRCA2 Genetic Mutation	Codes	1223 Prior Authorization Requirement
Testing and Related Genetic Counseling BRCA1 (BRCA1, DNA repair associated),	81162	Prior authorization is required. For additional information please reference BRCA1 & BRCA2 Genetic
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)		Mutation Testing and Related Genetic Counseling, MP-DE-1250
BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis	81163	Prior authorization is required. For additional information please reference BRCA1 & BRCA2 Genetic Mutation Testing and Related Genetic Counseling, MP-DE-1250
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)	81164	Prior authorization is required. For additional information please reference BRCA1 & BRCA2 Genetic Mutation Testing and Related Genetic Counseling, MP-DE-1250
BRCA1 (BRCA1, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene	81165	Prior authorization is required. For additional information please reference BRCA1 & BRCA2 Genetic Mutation Testing and Related Genetic Counseling, MP-DE-1250
nereditary breast and ovarian cancer) gene analysis; full sequence analysis BRCA1 (BRCA1, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; full duplication/deletion analysis (e, detection of large gene rearrangements)	81166	Prior authorization is required. For additional information please reference BRCA1 & BRCA2 Genetic Mutation Testing and Related Genetic Counseling, MP-DE-1250
analysis; full sequence analysis BRCA1 (BRCA1, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; full duplication/deletion analysis (ie,	81166 81167	
analysis, full sequence analysis BRCA1 (BRCA1, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; full duplication deletion analysis (e, detection of large gene rearrangements) BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; full duplication/deletion analysis (e)		Mutation Testing and Related Genetic Counseling, MP-DE-1250 Prior authorization is required. For additional information please reference BRCA1 & BRCA2 Genetic

BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene	81216	Prior authorization is required. For additional information please reference BRCA1 & BRCA2 Genetic Mutation Testing and Related Genetic Counseling, MP-DE-1250
analysis; full sequence analysis BRCA2 (BRCA2, DNA repair associated) (eg,	81217	Prior authorization is required. For additional information please reference BRCA1 & BRCA2 Genetic
hereditary breast and ovarian cancer) gene analysis; known familial variant		Mutation Testing and Related Genetic Counseling, MP-DE-1250
Unlisted molecular pathology procedure	81479	Prior authorization is required. For additional information please reference BRCA1 & BRCA2 Genetic Mutation Testing and Related Genetic Counseling, MP-DE-1250
Ultrasound Osteogenesis Stimulator Low intensity ultrasound stimulation to aid	Codes 20979	Prior Authorization Requirement Prior authorization is required. For additional information please reference Ultrasound Osteogenesis
bone healing, noninvasive (nonoperative)		Stimulator, MP-DE-1251
Coupling gel or paste, for use with ultrasound device, per oz		Prior authorization is required for billed charges greater than \$500. For additional information please reference Ultrasound Osteogenesis Stimulator, MP-DE-1251
Osteogenesis stimulator, electrical, noninvasive, other than spinal applications	E0747	Prior authorization is required for billed charges greater than \$500. For additional information please reference Ultrasound Osteogenesis Stimulator, MP-DE-1251
Osteogenesis stimulator, low intensity ultrasound, noninvasive	E0760	Prior authorization is required for billed charges greater than \$500. For additional information please reference Ultrasound Osteogenesis Stimulator, MP-DE-1251
Hyperhidrosis	Codes 17999	Prior Authorization Requirement Drior authorization is required. For additional information places reference Hyperhidronic AND DE 1127
Unlisted procedure, skin, mucous membrane and subcutaneous tissue		Prior authorization is required. For additional information please reference Hyperhidrosis, MP-DE-1137
Thoracoscopy, surgical; with thoracic sympathectomy Chemodenervation of eccrine glands; both	32664 64650	Prior authorization is required. For additional information please reference Hyperhidrosis, MP-DE-1137 Prior authorization is required. For additional information please reference Hyperhidrosis, MP-DE-1137
axillae Chemodenervation of eccrine glands; both Available chemodenervation of eccrine glands; other	64653	Prior authorization is required. For additional information please reference Hyperhidrosis, MP-DE-1137
area(s) (eg, scalp, face, neck), per day		
Tympanic neurectomy Application of a modality to 1 or more areas;	69676 97033	Prior authorization is required. For additional information please reference Hyperhidrosis, MP-DE-1137 Prior authorization is required. For additional information please reference Hyperhidrosis, MP-DE-1137
iontophoresis, each 15 minutes Suction assisted lipectomy; upper extremity	15878	Prior authorization is required. For additional information please reference Hyperhidrosis, MP-DE-1137
Injection, onabotulinumtoxinA, 1 unit	J0585	Prior authorization is required. For additional information please reference Hyperhidrosis, MP-DE-1137
Injection, rimabotulinumtoxinB, 100 units	J0587	Prior authorization is required. For additional information please reference Hyperhidrosis, MP-DE-1137
Concussion Testing Unlisted neurological or neuromuscular	95999	Prior Authorization Requirement Prior authorization is required. For additional information please reference Concussion Testing, MP-DE-1074
diagnostic procedure Psychological testing evaluation services by	96130	Prior authorization is required. For additional information please reference Concussion Testing, MP-DE-1074 Prior authorization is required. For additional information please reference Concussion Testing, MP-DE-1074
physician or other qualified health care		. 10. data reaction is required for additional miorination prease reiefferce concussion resting, MP-De-10/4
professional, including integration of patient data, interpretation of standardized test		
results and clinical data, clinical decision making, treatment planning and report, and		
interactive feedback to the patient, family member(s) or caregiver(s), when performed;		
first hour Psychological testing evaluation services by	96131	Prior authorization is required. For additional information please reference Concussion Testing, MP-DE-1074
physician or other qualified health care		,
professional, including integration of patient data, interpretation of standardized test		
results and clinical data, clinical decision making, treatment planning and report, and		
interactive feedback to the patient, family member(s) or caregiver(s), when performed;		
each additional hour (List separately in		
addition to code for primary procedure) Neuropsychological testing evaluation	96132	Prior authorization is required. For additional information please reference Concussion Testing, MP-DE-1074
services by physician or other qualified	30132	The data received the data and morning the data are contested in the data and the data are contested in the data are conte
health care professional, including integration of patient data, interpretation of standardized		
test results and clinical data, clinical decision making, treatment planning and report, and		
interactive feedback to the patient, family		
member(s) or caregiver(s), when performed; first hour		
Neuropsychological testing evaluation services by physician or other qualified	96133	Prior authorization is required. For additional information please reference Concussion Testing, MP-DE-1074
health care professional, including integration of patient data, interpretation of standardized		
test results and clinical data, clinical decision		
making, treatment planning and report, and interactive feedback to the patient, family		
member(s) or caregiver(s), when performed;		
each additional hour (List separately in addition to code for primary procedure)		
Psychological or neuropsychological test	96136	Prior authorization is required. For additional information please reference Concussion Testing, MP-DE-1074
administration and scoring by physician or other qualified health care professional, two		
or more tests, any method; first 30 minutes Psychological or neuropsychological test	96137	Prior authorization is required. For additional information please reference Concussion Testing, MP-DE-1074
administration and scoring by physician or		22. 22. 22. 22. 22. 22. 22. 22. 22. 22.
other qualified health care professional, two or more tests, any method; each additional		
30 minutes (List separately in addition to code for primary procedure)		
Psychological or neuropsychological test administration, with single automated,	96146	Prior authorization is required. For additional information please reference Concussion Testing, MP-DE-1074
standardized instrument via electronic platform, with automated result only		
Anesthesia Provided in Conjuction with	Codes	Prior Authorization Requirement
Non-Covered Procedures Anesthesia for intraoral procedures,	00170	Prior authorization is required. For additional information please reference Anesthesia Provided in
including biopsy		Conjuction with Non-Covered Procedures, MP-DE-1075
Deep Sedation/General Anesthesia, initial 15 minutes.	D9222	Prior authorization is required. For additional information please reference Anesthesia Provided in Conjuction with Non-Covered Procedures, MP-DE-1075
Deep sedation/general anesthesia – each	D9223	Prior authorization is required. For additional information please reference Anesthesia Provided in
subsequent 15-minute increment. for intravenous moderate (conscious)	D9239	Conjuction with Non-Covered Procedures, MP-DE-1075 Prior authorization is required. For additional information please reference Anesthesia Provided in
sedation/analgesia, initial 15 minutes.		Conjuction with Non-Covered Procedures, MP-DE-1075
Intravenous moderate (conscious) sedation/analgesia – each subsequent 15-	D9243	Prior authorization is required. For additional information please reference Anesthesia Provided in Conjuction with Non-Covered Procedures, MP-DE-1075
minute increment.	D9248	Prior authorization is required. For additional information place reference Association Provided 2
Non-IV Conscious Sedation: Moderate sedation using pills or intramuscular	D2240	Prior authorization is required. For additional information please reference Anesthesia Provided in Conjuction with Non-Covered Procedures, MP-DE-1075
injection. Rhinomanometry	Codes	Prior Authorization Requirement
Nasal Function Studies, Eg,	92512	Prior authorization required. For additional information please reference Rhinomanometry, MP-DE-1179.
Rhinomanometry	Codes	Dries Authorization Requirement
Negative Pressure Wound Therapy Negative pressure wound therapy (eg,	97605	Prior Authorization Requirement Prior authorization is required. Please refer to Negative Pressure Wound Therapy, MP-DE-1039 for additional
vacuum assisted drainage collection), utilizing durable medical equipment (DME),		requirements.
including topical application(s), wound		
assessment, and instruction(s) for ongoing care, per session; total wound(s) surface		
area less than or equal to 50 square centimeters		
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Negative pressure wound therapy (eg,	97606	Prior authorization is required. Please refer to Negative Pressure Wound Therapy, MP-DE-1039 for additional
vacuum assisted drainage collection), utilizing durable medical equipment (DME),		requirements.
including topical application(s), wound		
care, per session; total wound(s) surface		
area greater than 50 square centimeters		
Wound care set, for negative pressure wound therapy electrical pump, includes all supplies	A6550	For billed charges greater than \$500, prior authorization is required. Please refer to Negative Pressure Wound Therapy, MP-DE-1039 for additional requirements.
and accessories		
Canister, disposable, used with suction pump, each	A7000	For billed charges greater than \$500, prior authorization is required. Please refer to Negative Pressure Wound
Canister, nondisposable, used with suction	A7001	Therapy, MP-DE-1039 for additional requirements. For billed charges greater than \$500, prior authorization is required. Please refer to Negative Pressure Wound
pump, each	7.7001	Therapy, MP-DE-1039 for additional requirements.
Negative pressure wound therapy electrical	E2402	For billed charges greater than \$500, prior authorization is required. Please refer to Negative Pressure Wound
pump, stationary or portable		Therapy, MP-DE-1039 for additional requirements.
Vision Therapy Orthoptic training; performed by a physician	Codes	Prior Authorization Requirement
or other qualified health care professional	92065	Prior authorization is required. For additional information please refer to Vision Therapy, MP-DE-1228.
Electromagnetic Navigational	Codes	Prior Authorization Requirement
Bronchoscopy Bronchoscopy, rigid or flexible, including	31626	Drive at the state of the state
fluoroscopic guidance, when performed; with	31020	Prior authorization is required. For additional information please refer to Electromagnetic Navigational Bronchoscopy, MP-DE-1230
placement of fiducial markers, single or multiple		
Bronchoscopy, rigid or flexible, including	31627	Prior authorization is required. For additional information please refer to Electromagnetic Navigational
fluoroscopic guidance, when performed; with		Bronchoscopy, MP-DE-1230
computer-assisted, image-guided navigation (List separately in addition to code for		
primary procedure(s))		
Posterior Tibial Nerve Stimulation Posterior tibial neurostimulation,	Codes 64566	Prior Authorization Requirement Prior authorization is required. For additional information please refer to Posterior Tibial Nerve Stimulation
percutaneous needle electrode, single	04300	Prior authorization is required. For additional information please refer to Posterior Tibial Nerve Stimulation, MP-DE-1237
treatment, includes programming	r-1	
Electrical Nerve Stimulation Open implantation of neurostimulator	Codes 64575	Prior Authorization Requirement Prior authorization is required. For additional information please refer to Electrical Nerve Stimulation, MP-
electrode array; peripheral nerve (excludes		DE-1238
sacral nerve) Open implantation of neurostimulator	64580	Prior authorization is required. For additional information please refer to Electrical Nerve Stimulation, MP-
electrode array; neuromuscular	04300	DE-1238
Revision or removal of peripheral	64585	Prior authorization is required. For additional information please refer to Electrical Nerve Stimulation, MP-
neurostimulator electrode array		DE-1238
Percutaneous implantation of neurostimulator	64553	Prior authorization is required. For additional information please refer to Electrical Nerve Stimulation, MP-
electrode array; cranial nerve		DE-1238
Electronic analysis of implanted	95976	Prior authorization is required. For additional information please refer to Electrical Nerve Stimulation, MP-
neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude,		DE-1238
pulse width, frequency [Hz], on/off cycling,		
burst, magnet mode, dose lockout, patient selectable parameters, responsive		
neurostimulation, detection algorithms, closed		
loop parameters, and passive parameters) by physician or other qualified health care		
professional; with simple cranial nerve		
neurostimulator pulse generator/transmitter programming by physician or other qualified		
health care professional		
Radiofrequency Ablation of Miscellaneous Solid Tumors	Codes	Prior Authorization Requirement
Miscellaneous Solid Tumors Ablation, open, 1 or more renal mass	50250	Prior Authorization Requirement Prior authorization is required. Please refer to Radiofrequency Ablation of Miscellaneous Solid Tumors, MP-
Miscellaneous Solid Tumors Ablation, open, 1 or more renal mass lesion(s), cryosurgical, including		·
Miscellaneous Solid Tumors Ablation, open, 1 or more renal mass lesion(s), cryosurgical, including intraoperative ultrasound guidance and monitoring, if performed		Prior authorization is required. Please refer to Radiofrequency Ablation of Miscellaneous Solid Tumors, MP-
Miscellaneous Solid Tumors Ablation, open, 1 or more renal mass lesion(s), cryosurgical, including intraoperative ultrasound guidance and monitoring, if performed Laparoscopy, surgical; ablation of renal mass		Prior authorization is required. Please refer to Radiofrequency Ablation of Miscellaneous Solid Tumors, MP- DE-1218 for additional requirements. Prior authorization is required. Please refer to Radiofrequency Ablation of Miscellaneous Solid Tumors, MP-
Miscellaneous Solid Tumors Ablation, open, 1 or more renal mass lesion(s), cryosurgical, including intraoperative ultrasound guidance and monitoring, if performed	50250	Prior authorization is required. Please refer to Radiofrequency Ablation of Miscellaneous Solid Tumors, MP- DE-1218 for additional requirements.
Miscellaneous Solid Tumors Abiation, open, 1 or more renal mass lesion(s), cryosurgical, including intraoperative ultrasound guidance and monitoring, if performed Laparoscopy, surgical; ablation of renal mass lesion(s), including intraoperative ultrasound guidance and monitoring, when performed	50250 50542	Prior authorization is required. Please refer to Radiofrequency Ablation of Miscellaneous Solid Tumors, MP- DE-1218 for additional requirements. Prior authorization is required. Please refer to Radiofrequency Ablation of Miscellaneous Solid Tumors, MP- DE-1218 for additional requirements.
Miscellaneous Solid Tumors Ablation, open, 1 or more renal mass lesion(s), cryosurgical, including intraoperative ultrasound guidance and monitoring, if performed Laparoscopy, surgical, ablation of renal mass lesion(s), including intraoperative ultrasound	50250	Prior authorization is required. Please refer to Radiofrequency Ablation of Miscellaneous Solid Tumors, MP- DE-1218 for additional requirements. Prior authorization is required. Please refer to Radiofrequency Ablation of Miscellaneous Solid Tumors, MP- DE-1218 for additional requirements. Prior authorization is required. Please refer to Radiofrequency Ablation of Miscellaneous Solid Tumors, MP-
Miscellaneous Solid Tumors Ablation, open, 1 or more renal mass lesion(s), cryosurgical, including intraoperative ultrasound guidance and monitoring, if performed Laparoscopy, surgical; ablation of renal mass lesion(s), including intraoperative ultrasound guidance and monitoring, when performed Ablation, renal tumor(s), unilateral,	50250 50542 50593	Prior authorization is required. Please refer to Radiofrequency Ablation of Miscellaneous Solid Tumors, MP- DE:1218 for additional requirements. Prior authorization is required. Please refer to Radiofrequency Ablation of Miscellaneous Solid Tumors, MP- DE:1218 for additional requirements. Prior authorization is required. Please refer to Radiofrequency Ablation of Miscellaneous Solid Tumors, MP- DE:1218 for additional requirements.
Miscellaneous Solid Tumors Ablation, open, 1 or more renal mass lesion(s), cryosurgical, including intraoperative ultrasound guidance and monitoring, if performed Laparoscopy, surgical, ablation of renal mass lesion(s), including intraoperative ultrasound guidance and monitoring, when performed Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy	50250 50542	Prior authorization is required. Please refer to Radiofrequency Ablation of Miscellaneous Solid Tumors, MP- DE-1218 for additional requirements. Prior authorization is required. Please refer to Radiofrequency Ablation of Miscellaneous Solid Tumors, MP- DE-1218 for additional requirements. Prior authorization is required. Please refer to Radiofrequency Ablation of Miscellaneous Solid Tumors, MP-
Miscellaneous Solid Tumors Ablation, open, 1 or more renal mass lesion(s), cryosurgical, including intraoperative ultrasound guidance and monitoring, if performed Laparoscopy, surgical; ablation of renal mass lesion(s), including intraoperative ultrasound guidance and monitoring, when performed Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy Ablation, 1 or more renal tumor(s), percutaneous, unilateral, radiofrequency Bronchoscopy, rigid or flexible, including	50250 50542 50593	Prior authorization is required. Please refer to Radiofrequency Ablation of Miscellaneous Solid Tumors, MP-DE-1218 for additional requirements. Prior authorization is required. Please refer to Radiofrequency Ablation of Miscellaneous Solid Tumors, MP-DE-1218 for additional requirements. Prior authorization is required. Please refer to Radiofrequency Ablation of Miscellaneous Solid Tumors, MP-DE-1218 for additional requirements. Prior authorization is required. Please refer to Radiofrequency Ablation of Miscellaneous Solid Tumors, MP-DE-1218 for additional requirements. Prior authorization is required. Please refer to Radiofrequency Ablation of Miscellaneous Solid Tumors, MP-DE-1218 for additional requirements.
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Miscellaneous Solid Tumors Ablation, open, 1 or more renal mass tesion(s), cryosurgical, including intraoperative ultrasound guidance and monitoring, if performed Laparoscopy, surgical; ablation of renal mass tesion(s), including intraoperative ultrasound guidance and monitoring, when performed Ablation, renal tumor(s), unitateral, percutaneous, cryotherapy Ablation, 1 or more renal tumor(s), percutaneous, unitateral, radiofrequency Bronchoscopy, rigid or flexible, including fluroroscopic guidance, when performed; with destruction of tumor or relief of stenosis by any method other than excision (e), laser	50250 50542 50593 50592	Prior authorization is required. Please refer to Radiofrequency Ablation of Miscellaneous Solid Tumors, MP-DE-1218 for additional requirements. Prior authorization is required. Please refer to Radiofrequency Ablation of Miscellaneous Solid Tumors, MP-DE-1218 for additional requirements. Prior authorization is required. Please refer to Radiofrequency Ablation of Miscellaneous Solid Tumors, MP-DE-1218 for additional requirements. Prior authorization is required. Please refer to Radiofrequency Ablation of Miscellaneous Solid Tumors, MP-DE-1218 for additional requirements. Prior authorization is required. Please refer to Radiofrequency Ablation of Miscellaneous Solid Tumors, MP-DE-1218 for additional requirements.
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Miscellaneous Solid Tumors Ablation, open, 1 or more renal mass tesion(s), cryosurgical, including intraoperative ultrasound guidance and monitoring, if performed Laparoscopy, surgical, ablation of renal mass tesion(s), including intraoperative ultrasound guidance and monitoring, when performed Ablation, renal tumor(s), unlateral, percutaneous, cryotherapy Ablation, 1 or more renal tumor(s), percutaneous, unilateral, radiofrequency Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with destruction of tumor or relief of stenosis by any method other than excision (eg. laser therapy, cryotherapy) Ablation therapy for reduction or aredication of 1 or more pulmonary tumor(s) including pleurar or chest wall when involved by tumor	50250 50542 50593 50592 31641	Prior authorization is required. Please refer to Radiofrequency Ablation of Miscellaneous Solid Tumors, MP- DE-1218 for additional requirements. Prior authorization is required. Please refer to Radiofrequency Ablation of Miscellaneous Solid Tumors, MP- DE-1218 for additional requirements. Prior authorization is required. Please refer to Radiofrequency Ablation of Miscellaneous Solid Tumors, MP- DE-1218 for additional requirements. Prior authorization is required. Please refer to Radiofrequency Ablation of Miscellaneous Solid Tumors, MP- DE-1218 for additional requirements. Prior authorization is required. Please refer to Radiofrequency Ablation of Miscellaneous Solid Tumors, MP- DE-1218 for additional requirements.
Miscellaneous Solid Tumors Ablation, open, 1 or more renal mass tesion(s), cryosurgical, including intraoperative ultrasound guidance and monitoring. If performed Laparoscopy, surgical, ablation of renal mass tesion(s), including intraoperative ultrasound guidance and monitoring, when performed Ablation, renal tumor(s), unlateral, percutaneous, unlateral, radiofrequency Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with destruction of tumor or relief of stenosis by any method other than existion (e), laser therapy, cryotherapy) Ablation therapy for reduction or aradication of 1 or more pulmonary tumor(s) including pleura or chest wall when involved by tumor extension, percutaneous, including imaging guidance when performed, unlateral;	50250 50542 50593 50592 31641	Prior authorization is required. Please refer to Radiofrequency Ablation of Miscellaneous Solid Tumors, MP- DE-1218 for additional requirements. Prior authorization is required. Please refer to Radiofrequency Ablation of Miscellaneous Solid Tumors, MP- DE-1218 for additional requirements. Prior authorization is required. Please refer to Radiofrequency Ablation of Miscellaneous Solid Tumors, MP- DE-1218 for additional requirements. Prior authorization is required. Please refer to Radiofrequency Ablation of Miscellaneous Solid Tumors, MP- DE-1218 for additional requirements. Prior authorization is required. Please refer to Radiofrequency Ablation of Miscellaneous Solid Tumors, MP- DE-1218 for additional requirements.
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Arthrocentesis, aspiration and/or	20606	Prior authorization is required. For additional information please refer to Ultrasound Guidance for Joint,
injection: intermediate joint or bursa		Tendon, Tendon Sheath, and Trigger Point Injections, MP-DE-1253
(e.g., temporomandibular,		readon, readon steath, and migger route injections, the DE 1255
acromioclavicular, wrist, elbow or ankle,		
olecranon bursa); with ultrasound		
guidance, with permanent recording and		
reporting		
Arthrocentesis, aspiration and/or	20610	Prior authorization is required. For additional information please refer to Ultrasound Guidance for Joint,
injection; major joint or bursa (e.g.,		Tendon, Tendon Sheath, and Trigger Point Injections, MP-DE-1253
shoulder, hip, knee joint, subacromial		
bursa); without ultrasound guidance		
Arthrocentesis, aspiration and/or	20611	Prior authorization is required. For additional information please refer to Ultrasound Guidance for Joint,
injection: major joint or bursa (e.g.,		Tendon, Tendon Sheath, and Trigger Point Injections, MP-DE-1253
shoulder, hip, knee joint, subacromial		readon, readon sheath, and miget rome injections, in the 1233
bursa); with ultrasound guidance, with		
permanent recording and reporting		
Injection(s); single tendon sheath, or	20550	Prior authorization is required. For additional information please refer to Ultrasound Guidance for Joint,
ligament, aponeurosis (e.g., plantar		Tendon, Tendon Sheath, and Trigger Point Injections, MP-DE-1253
"fascia"		
Injection(s); single tendon origin/insertion	20551	Prior authorization is required. For additional information please refer to Ultrasound Guidance for Joint,
		Tendon, Tendon Sheath, and Trigger Point Injections, MP-DE-1253
Injection(s); single or multiple trigger	20552	Prior authorization is required. For additional information please refer to Ultrasound Guidance for Joint,
i-t(-) 1 2	20302	
point(s), 1 or 2 muscle(s)		Tendon, Tendon Sheath, and Trigger Point Injections, MP-DE-1253
Injection(s); single or multiple trigger	20553	Prior authorization is required. For additional information please refer to Ultrasound Guidance for Joint,
point(s), 3 or more muscle(s)		Tendon, Tendon Sheath, and Trigger Point Injections, MP-DE-1253
	76942	
Ultrasonic guidance for needle	10342	Prior authorization is required. For additional information please refer to Ultrasound Guidance for Joint,
placement (e.g., biopsy, aspiration,		Tendon, Tendon Sheath, and Trigger Point Injections, MP-DE-1253
injection, localization device), imaging		
supervision and interpretation		
Ultrasound, extremity, nonvascular, real-	76882	Prior authorization is required. For additional information please refer to Ultrasound Guidance for Joint,
time with image documentation; limited,		Tendon, Tendon Sheath, and Trigger Point Injections, MP-DE-1253
anatomic specific		
DME Policies	Codes	Prior Authorization Requirement
Myolectric Upper Extremity Orthoses	L6026, L6704,L6715, L6880, L6890,	For billed charges greater than \$500, prior authorization is required. Please refer to Myolectric Upper
	L6895,L6925,L6930,L6935,L6945,	Extremity Orthoses, MP-DE-1031 for additional requirements.
	L6955,L6965,L6965, L6975,L7007, L7008, L7009,	
	L7045, L7180, L7181,L7190,L7191	
Home Oxygen Therapy	A4606	For billed charges greater than \$500, prior authorization is required. Please refer to Home Oxygen Therapy,
	A4608	MP-DE-1030 for additional requirements.
	A4615	· ·
	A4616	
	A4617	
	A4619	
	A4620	
	IEO 424	
	E0424	
	E0425	
	E0425	
	E0425 E0430 E0431	
	E0425 E0430 E0431 E0433	
	E0425 E0430 E0431 E0433 E0433	
	E0425 E0430 E0431 E0433 E0434 E0435	
	E0425 E0430 E0431 E0433 E0434 E0435 E0435 E0435	
	E0425 E0430 E0431 E0433 E0434 E0435 E0435 E0435	
	E0425 E0430 E0431 E0433 E0434 E0435 E0439 E0440	
	E0425 E0430 E0431 E0433 E0434 E0435 E0439 E0440 E0440	
	E0425 E0430 E0431 E0433 E0434 E0435 E0439 E0440 E0441 E0442	
	E0425 E0430 E0431 E0433 E0434 E0435 E0439 E0440 E0441 E0442 E0442	
	E0425 E0430 E0431 E0433 E0434 E0435 E0439 E0440 E0441 E0442	
	E0425 E0430 E0431 E0433 E0434 E0435 E0439 E0440 E0441 E0442 E0442	
	E0425 E0430 E0431 E0433 E0434 E0435 E0449 E0440 E0441 E0442 E0443 E0445 E0445	
	E0425 E0430 E0431 E0433 E0434 E0435 E0445 E0440 E0441 E0442 E0443 E0445 E0447 E0447	
	E0425 E0430 E0431 E0433 E0434 E0435 E0449 E0440 E0441 E0442 E0443 E0445 E0447 E0445	
	E0425 E0430 E0431 E0433 E0434 E0435 E0449 E0440 E0441 E0442 E0442 E0445 E0447 E0455 E0555	
	E0425 E0430 E0431 E0433 E0434 E0435 E0449 E0440 E0441 E0442 E0443 E0445 E0447 E0445	
	E0425 E0430 E0431 E0433 E0434 E0435 E0439 E0440 E0441 E0442 E0443 E0445 E0447 E0445 E0455	
	E0425 E0430 E0431 E0433 E0434 E0435 E0449 E0441 E0441 E0442 E0443 E0445 E0447 E0455 E0550 E0555	
	E0425 E0430 E0431 E0433 E0434 E0435 E0449 E0441 E0441 E0441 E0442 E0443 E0445 E0447 E0455 E0555 E0560 E0585 E1352	
High Frequency Chest Wall Oscillation	E0425 E0430 E0431 E0433 E0434 E0435 E0440 E0441 E0442 E0443 E0445 E0447 E0455 E0550 E0555 E0555 E0555 E0555 E0555 A7020	For billed charges greater than \$500, prior authorization is required. Please refer to High Frequency Chest
High Frequency Chest Wall Oscillation Devices	E0425 E0430 E0431 E0433 E0434 E0435 E0449 E0441 E0441 E0441 E0442 E0443 E0445 E0447 E0455 E0555 E0560 E0585 E1352	For billed charges greater than \$500, prior authorization is required. Please refer to High Frequency Chest Wall Oscillation Devices, MP-DE-1141 for additional requirements.
	E0425 E0430 E0431 E0433 E0434 E0435 E0449 E0444 E0445 E0444 E0445 E0447 E0550 E0550 E0555 E0550 E0565 E1352 A7020 A7025	
	E0425 E0430 E0431 E0433 E0434 E0435 E0439 E0440 E0441 E0442 E0443 E0447 E0447 E0455 E0550 E0555 E0556 E0555 E0556 E0588 E13352 A7020 A7025	
	E0425 E0430 E0431 E0433 E0434 E0435 E0440 E0440 E0441 E0442 E0443 E0445 E0447 E0455 E0550 E0555 E0555 E0555 E0555 E0555 E0556 E05585 E13352 A7020 A7025 A7026 E0482	
Devices	E0425 E0430 E0431 E0433 E0434 E0435 E0449 E0440 E0441 E0443 E0445 E0447 E0555 E0550 E0555 E0560 E0555 E1352 A7020 A7025 A7026 E0483 E0483	Wall Oscillation Devices, MP-DE-1141 for additional requirements.
Devices	E0425 E0430 E0431 E0433 E0434 E0435 E0449 E0440 E0441 E0443 E0445 E0447 E0555 E0550 E0555 E0560 E0555 E1352 A7020 A7025 A7026 E0483 E0483	Wall Oscillation Devices, MP-DE-1141 for additional requirements.
	E0425 E0430 E0431 E0433 E0434 E0435 E0439 E0440 E0441 E0442 E0443 E0445 E0455 E0550 E0555 E0555 E0555 E0555 E0556 E0585 E0585 E0585 E0585 E0585 E0585 E0585 E0586 E0585 E0586	Wall Oscillation Devices, MP-DE-1141 for additional requirements. For billed charges greater than \$500, prior authorization is required. Please refer to Pneumatic Compression
Devices	E0425 E0430 E0431 E0433 E0434 E0433 E0440 E0441 E0441 E0442 E0443 E0447 E0455 E0550 E0555 E0555 E0555 E0555 E0560 E0585 E1352 A7020 A7025 A7026 E0482 E0483 E0660	Wall Oscillation Devices, MP-DE-1141 for additional requirements.
Devices	E0425 E0430 E0431 E0433 E0434 E0435 E0439 E0440 E0441 E0442 E0443 E0447 E0445 E0545 E0550 E0555 E0550 E0558 E1352 A7020 A7025 A7026 E0482 E0483 E0650 E0651 E0651	Wall Oscillation Devices, MP-DE-1141 for additional requirements. For billed charges greater than \$500, prior authorization is required. Please refer to Pneumatic Compression
Devices	E0425 E0430 E0431 E0433 E0434 E0435 E0440 E0441 E0442 E0442 E0443 E0447 E0455 E0550 E0555 E0555 E0555 E1352 A7020 A7025 A7025 A7026 E0482 E0483 E0465 E0650 E0661 E06651 E0665	Wall Oscillation Devices, MP-DE-1141 for additional requirements. For billed charges greater than \$500, prior authorization is required. Please refer to Pneumatic Compression
Devices	E0425 E0430 E0431 E0433 E0434 E0435 E0439 E0440 E0441 E0442 E0443 E0447 E0445 E0545 E0550 E0555 E0550 E0558 E1352 A7020 A7025 A7026 E0482 E0483 E0650 E0651 E0651	Wall Oscillation Devices, MP-DE-1141 for additional requirements. For billed charges greater than \$500, prior authorization is required. Please refer to Pneumatic Compression
Devices	E0425 E0430 E0431 E0433 E0434 E0435 E0440 E0441 E0442 E0442 E0443 E0447 E0455 E0550 E0555 E0555 E0555 E1352 A7020 A7025 A7025 A7026 E0482 E0483 E0465 E0650 E0661 E06651 E0665	Wall Oscillation Devices, MP-DE-1141 for additional requirements. For billed charges greater than \$500, prior authorization is required. Please refer to Pneumatic Compression
Devices	E0425 E0430 E0431 E0433 E0434 E0435 E0440 E0441 E0442 E0442 E0443 E0445 E0447 E0455 E0550 E0555 E0555 E0555 E0555 E0556 E0566 E0585 E0482 E0483 E0483 E0483 E0486 E0486 E0486 E0486 E0486 E0486 E0586 E0586 E0586 E0586 E0586 E0586 E0586 E0586 E0686	Wall Oscillation Devices, MP-DE-1141 for additional requirements. For billed charges greater than \$500, prior authorization is required. Please refer to Pneumatic Compression
Devices	E0425 E0430 E0431 E0433 E0434 E0433 E0440 E0441 E0443 E0442 E0443 E0447 E0455 E0550 E0555 E0555 E0555 E0565 E1352 A7020 A7025 A7026 E0482 E0483 E0665 E0665 E0665 E0665	Wall Oscillation Devices, MP-DE-1141 for additional requirements. For billed charges greater than \$500, prior authorization is required. Please refer to Pneumatic Compression
Devices	E0425 E0430 E0431 E0433 E0434 E0435 E0439 E0440 E0441 E0442 E0443 E0445 E0447 E0445 E0455 E0550 E0555 E0556 E0558 E0556 E0566 E0588 E13352 A7020 A7025 A7026 E0482 E0483 E0660 E0651 E0665 E0665 E0666 E0666	Wall Oscillation Devices, MP-DE-1141 for additional requirements. For billed charges greater than \$500, prior authorization is required. Please refer to Pneumatic Compression
Devices	E0425 E0430 E0431 E0433 E0434 E0433 E0440 E0441 E0443 E0442 E0443 E0447 E0455 E0550 E0555 E0555 E0555 E0565 E1352 A7020 A7025 A7026 E0482 E0483 E0665 E0665 E0665 E0665	Wall Oscillation Devices, MP-DE-1141 for additional requirements. For billed charges greater than \$500, prior authorization is required. Please refer to Pneumatic Compression
Devices	E0425 E0430 E0431 E0433 E0434 E0435 E0440 E0441 E0442 E0442 E0443 E0445 E0447 E0455 E0550 E0555 E0555 E0555 E0556 E0566 E05685 E1332 A7020 A7025 A7026 E0483 E0483 E0483 E0483 E0486 E0486 E0486 E0666 E0665 E0666	Wall Oscillation Devices, MP-DE-1141 for additional requirements. For billed charges greater than \$500, prior authorization is required. Please refer to Pneumatic Compression
Devices	E0425 E0430 E0431 E0433 E0434 E0435 E0439 E0440 E0441 E0442 E0443 E0447 E0445 E0545 E0550 E0555 E0550 E0558 E0550 E0560 E0585 E0560 E0585 E0560 E0585 E0560 E0585 E0560 E0585 E0560 E0686	Wall Oscillation Devices, MP-DE-1141 for additional requirements. For billed charges greater than \$500, prior authorization is required. Please refer to Pneumatic Compression
Devices	E0425 E0430 E0431 E0433 E0434 E0435 E0440 E0441 E0442 E0443 E0445 E0447 E0455 E0550 E0555 E0555 E0555 E0555 E0556 E0566 E0665 E0665 E0665 E0665 E0665 E0666 E0666 E0666 E0666 E0666 E0666	Wall Oscillation Devices, MP-DE-1141 for additional requirements. For billed charges greater than \$500, prior authorization is required. Please refer to Pneumatic Compression
Devices	E0425 E0430 E0431 E0433 E0434 E0435 E0440 E0441 E0442 E0442 E0443 E0447 E0455 E0550 E0555 E0555 E0555 E0555 E0355 E1352 A7020 A7025 A7026 E0482 E0483 E0660 E0661 E0665 E0665 E0666	Wall Oscillation Devices, MP-DE-1141 for additional requirements. For billed charges greater than \$500, prior authorization is required. Please refer to Pneumatic Compression
Devices	E0425 E0430 E0431 E0433 E0434 E0435 E0439 E0440 E0441 E0442 E0443 E0445 E0447 E0455 E0550 E0555 E0555 E0555 E0556 E0566 E0665 E0665 E0665 E0665 E0665 E0666 E0666 E0666 E0666 E0666 E0666	Wall Oscillation Devices, MP-DE-1141 for additional requirements. For billed charges greater than \$500, prior authorization is required. Please refer to Pneumatic Compression
Devices	E0425 E0430 E0431 E0433 E0434 E0435 E0440 E0441 E0442 E0442 E0443 E0447 E0455 E0550 E0555 E0555 E0555 E0555 E0355 E1352 A7020 A7025 A7026 E0482 E0483 E0660 E0661 E0665 E0665 E0666	Wall Oscillation Devices, MP-DE-1141 for additional requirements. For billed charges greater than \$500, prior authorization is required. Please refer to Pneumatic Compression
Devices	E0425 E0430 E0431 E0433 E0434 E0435 E0440 E0441 E0442 E0442 E0443 E0445 E0447 E0455 E0550 E0555 E0555 E0555 E0556 E0556 E0558 E1352 E1352 E0448 E0448 E0448 E0466 E0560 E0661 E0665 E06666	Wall Oscillation Devices, MP-DE-1141 for additional requirements. For billed charges greater than \$500, prior authorization is required. Please refer to Pneumatic Compression
Devices	E0425 E0430 E0431 E0433 E0434 E0435 E0439 E0440 E0441 E0442 E0443 E0445 E0447 E0455 E0550 E0555 E0555 E0555 E0555 E0556 E0585 E0586 E0585 E0586 E0585 E0483 E0666 E0666 E0667 E0666 E0666 E0666 E0666 E0666 E0666 E0666 E0666	Wall Oscillation Devices, MP-DE-1141 for additional requirements. For billed charges greater than \$500, prior authorization is required. Please refer to Pneumatic Compression

Coverage for Hearing Aids	lurana	In this to the drop of the second of the sec
	V5030 V5040	For billed charges greater than \$500, prior authorization is required. Please refer to Coverage for Hearing Aids, MP-DE-1140 for additional requirements.
1	V5050	mass, m. Sc 1140 for additional requirements.
1	V5060	
1	V5070	
1	V5080	
1	V5090 V5095	
	V5100	
1	V5120	
	V5130	
	V5140 V5150	
	V5171	
	V5172	
	V5181	
	V5190	
	V5230 V5242	
	V5243	
	V5244	
	V5245	
	V5246 V5247	
	V5247 V5248	
	V5249	
	V5250	
Beds, Accessories and Related Items	E0250	For billed charges greater than \$500, prior authorization is required. Please refer to Beds, Accessories and
	E0251	Related Items, MP-DE-1183 for additional requirements.
1	E0255 E0256	
1	E0256 E0290	
1	E0291	
1	E0292	
1	E0293	
1	E0294 E0295	
1	E0295 E0296	
1	E0297	
1	E0260	
1	E0261 E0265	
	E0266	
	E0193	
	E0194	
	E0300	
	E0328 E0329	
	E0301	
	E0302	
	E0303	
	E0304	
	E0184 E0185	
External Hearing Aids, Auditory Brainstem	V5030	For billed charges greater than \$500, prior authorization is required. Please refer to External Hearing Aids,
	V5040	Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing, MP-DE-1190 for
and Audiological Testing	V5050	additional requirements.
	V5060	
	V5070 V5080	
	V5100	
	V5120	
	V5130	
	V5140 V5150	
	V5171	
1	V5172	
1	V5181	
1	V5211 V5212	
1	V5212 V5213	
1	V5214	
1	V5215	
1	V5221 V5230	
1	V5242	
1	V5243	
1	V5244	
1	V5245 V5246	
1	V5247	
Functional Neuromuscular Electrical	V5247 A4595	For billed charges greater than \$500, prior authorization is required. Please refer to Functional
Stimulation and Other Electrical	A4595 E0745	Neuromuscular Electrical Stimulation and Other Electrical Stimulator, MP-DE-1185 for additional
	A4595 E0745 E0764	
Stimulation and Other Electrical Stimulator	A4595 E0745 E0764 E0770	Neuromuscular Electrical Stimulation and Other Electrical Stimulator, MP-DE-1185 for additional requirements.
Stimulation and Other Electrical	A4595 E0745 E0764	Neuromuscular Electrical Stimulation and Other Electrical Stimulator, MP-DE-1185 for additional requirements. For billed charges greater than \$500, prior authorization is required. Please refer to Home Apnea Monitors,
Stimulation and Other Electrical Stimulator	A4595 E0745 E0764 E0770	Neuromuscular Electrical Stimulation and Other Electrical Stimulator, MP-DE-1185 for additional requirements. For billed charges greater than \$500, prior authorization is required. Please refer to Home Apnea Monitors, MP-DE-1069 for additional requirements. For billed charges greater than \$500, prior authorization is required. Please refer to Home Dialysis Equipment
Stimulation and Other Electrical Stimulator Home Apnea Monitors	A4595 E0745 E0754 E0776 E0618, E0619, E1933 A4245, A4653, A4657, A4660, A4663, A4670, A4671, A4672, A4673, A4674, A4728, A4927, A4930, E0210,	Neuromuscular Electrical Stimulation and Other Electrical Stimulator, MP-DE-1185 for additional requirements. For billed charges greater than \$500, prior authorization is required. Please refer to Home Apnea Monitors, MP-DE-1069 for additional requirements.
Stimulation and Other Electrical Stimulator Home Apnea Monitors	A4595 E0745 E0764 E0770 E0618, E0619, E1933 A4245, A4653, A4657, A4660, A4663, A4670, A4671, A4672, A4673, A4674, A4728, A4927, A4930, E0210, E1510, E1520, E1530, E1540, E1550, E1550, E1570,	Neuromuscular Electrical Stimulation and Other Electrical Stimulator, MP-DE-1185 for additional requirements. For billed charges greater than \$500, prior authorization is required. Please refer to Home Apnea Monitors, MP-DE-1069 for additional requirements. For billed charges greater than \$500, prior authorization is required. Please refer to Home Dialysis Equipment
Stimulation and Other Electrical Stimulator Home Apnea Monitors	A4595 E0745 E0774 E0618, E0619, E1933 A4245, A4653, A4657, A4660, A4663, A4670, A4671, A4672, A4673, A4674, A4728, A4927, A4930, E0210, E1510, E1520, E1530, E1540, E1550, E1560, E1570, E1575, E1580, E1590, E1592, E1594, E1600, E1610,	Neuromuscular Electrical Stimulation and Other Electrical Stimulator, MP-DE-1185 for additional requirements. For billed charges greater than \$500, prior authorization is required. Please refer to Home Apnea Monitors, MP-DE-1069 for additional requirements. For billed charges greater than \$500, prior authorization is required. Please refer to Home Dialysis Equipment
Stimulation and Other Electrical Stimulator Home Apnea Monitors	A4595 E0745 E0764 E0770 E0618, E0619, E1933 A4245, A4653, A4657, A4660, A4663, A4670, A4671, A4672, A4673, A4674, A4728, A4927, A4930, E0210, E1510, E1520, E1530, E1540, E1550, E1550, E1570,	Neuromuscular Electrical Stimulation and Other Electrical Stimulator, MP-DE-1185 for additional requirements. For billed charges greater than \$500, prior authorization is required. Please refer to Home Apnea Monitors, MP-DE-1069 for additional requirements. For billed charges greater than \$500, prior authorization is required. Please refer to Home Dialysis Equipment
Stimulation and Other Electrical Stimulator Home Apnea Monitors Home Dialysis Equipment and Supplies	A4595 E0745 E0754 E0754 E0769 E0618, E0619, E1933 A4245, A4653, A4657, A4660, A4663, A4670, A4671, A4672, A4673, A4674, A4728, A4927, A4930, E0210, E1510, E1520, E1530, E1540, E1550, E1560, E1570, E1575, E1580, E1590, E1592, E1594, E1600, E1610, E1615, E1620, E1625, E1630, E1632, E1634, E1635, E1636, E1699	Neuromuscular Electrical Stimulation and Other Electrical Stimulator, MP-DE-1185 for additional requirements. For billed charges greater than \$500, prior authorization is required. Please refer to Home Apnea Monitors, MP-DE-1069 for additional requirements. For billed charges greater than \$500, prior authorization is required. Please refer to Home Dialysis Equipment and Supplies, MP-DE-1070 for additional requirements.
Stimulation and Other Electrical Stimulator Home Apnea Monitors	A4595 E0745 E0776 E0754 E0770 E0618, E0619, E1933 A4245, A4653, A4657, A4660, A4663, A4670, A4671, A4672, A4673, A4674, A4728, A4927, A4930, E0210, E1510, E1520, E1530, E1540, E1550, E1560, E1570, E1575, E1580, E1590, E1592, E1594, E1600, E1610, E1615, E1620, E1625, E1630, E1632, E1634, E1635,	Neuromuscular Electrical Stimulation and Other Electrical Stimulator, MP-DE-1185 for additional requirements. For billed charges greater than \$500, prior authorization is required. Please refer to Home Apnea Monitors, MP-DE-1069 for additional requirements. For billed charges greater than \$500, prior authorization is required. Please refer to Home Dialysis Equipment
Stimulation and Other Electrical Stimulator Home Apnea Monitors Home Dialysis Equipment and Supplies	A4595 E0745 E0776 E0618, E0619, E1933 A4245, A4653, A4657, A4660, A4663, A4670, A4671, A4672, A4673, A4674, A4728, A4927, A4930, E0210, E1510, E1520, E1530, E1540, E1550, E1560, E1570, E1575, E1580, E1590, E1592, E1594, E1600, E1610, E1615, E1620, E1625, E1630, E1632, E1634, E1635, E1636, E1699 E1902, E2500, E2502, E2504, E2506, E2508, E2510, E2511, E2512, E2599 A4606, A4608, A4615, A4617, A4619, A4620,	Neuromuscular Electrical Stimulation and Other Electrical Stimulator, MP-DE-1185 for additional requirements. For billed charges greater than \$500, prior authorization is required. Please refer to Home Apnea Monitors, MP-DE-1069 for additional requirements. For billed charges greater than \$500, prior authorization is required. Please refer to Home Dialysis Equipment and Supplies, MP-DE-1070 for additional requirements. For billed charges greater than \$500, prior authorization is required. Please refer to Speech Generating Devices, MP-DE-1077 for additional requirements. For billed charges greater than \$500, prior authorization is required. Please refer to Speech Generating Devices, MP-DE-1077 for additional requirements.
Stimulation and Other Electrical Stimulator Home Apnea Monitors Home Dialysis Equipment and Supplies Speech Generating Devices	A4595 £0745 £0754 £0776 £0770 £0618, £0619, £1933 A4245, A4653, A4657, A4660, A4663, A4670, A4671, A4672, A4673, A4674, A4728, A4927, A4930, £0210, £1530, £1530, £1530, £1530, £1550, £1560, £1570, £1575, £1580, £1590, £1592, £1594, £1600, £1610, £1615, £1620, £1625, £1630, £1632, £1634, £1635, £1636, £1639 £1902, £2500, £2502, £2504, £2506, £2508, £2510, £2511, £2512, £2599 A4606, A4608, A4615, A4617, A4619, A4620, £0424, £04245, £0439, £0440, £04441, £04442, £04447,	Neuromuscular Electrical Stimulation and Other Electrical Stimulator, MP-DE-1185 for additional requirements. For billed charges greater than \$500, prior authorization is required. Please refer to Home Apnea Monitors, MP-DE-1069 for additional requirements. For billed charges greater than \$500, prior authorization is required. Please refer to Home Dialysis Equipment and Supplies, MP-DE-1070 for additional requirements. For billed charges greater than \$500, prior authorization is required. Please refer to Speech Generating Devices, MP-DE-1077 for additional requirements.
Stimulation and Other Electrical Stimulator Home Apnea Monitors Home Dialysis Equipment and Supplies Speech Generating Devices	A4595 E0745 E0764 E0770 E0618, E0619, E1933 A4245, A4653, A4657, A4660, A4663, A4670, A4671, A4672, A4673, A4674, A4728, A4927, A4930, E0210, E1510, E1520, E1530, E1540, E1550, E1560, E1570, E1575, E1580, E1590, E1592, E1594, E1600, E1610, E1615, E1620, E1625, E1630, E1632, E1634, E1635, E1636, E1699 E1902, E2500, E2502, E2504, E2506, E2508, E2510, E2511, E2512, E2599 A4606, A4608, A4615, A4616, A4617, A4619, A4620, E0424, E0425, E0439, E0440, E0441, E0442, E0447, E0550, E0560, E1352, E1333, E1334, E1355, E1357,	Neuromuscular Electrical Stimulation and Other Electrical Stimulator, MP-DE-1185 for additional requirements. For billed charges greater than \$500, prior authorization is required. Please refer to Home Apnea Monitors, MP-DE-1069 for additional requirements. For billed charges greater than \$500, prior authorization is required. Please refer to Home Dialysis Equipment and Supplies, MP-DE-1070 for additional requirements. For billed charges greater than \$500, prior authorization is required. Please refer to Speech Generating Devices, MP-DE-1077 for additional requirements. For billed charges greater than \$500, prior authorization is required. Please refer to Speech Generating Devices, MP-DE-1077 for additional requirements.
Stimulation and Other Electrical Stimulator Home Apnea Monitors Home Dialysis Equipment and Supplies Speech Generating Devices	A4595 E0745 E0776 E0618, E0619, E1933 A4245, A4653, A4657, A4660, A4663, A4670, A4671, A4672, A4673, A4674, A4728, A4927, A4930, E0210, E1510, E1520, E1530, E1540, E1550, E1560, E1570, E1575, E1580, E1590, E1592, E1694, E1600, E1610, E1615, E1620, E1625, E1630, E1632, E1634, E1635, E1636, E1699 E1902, E2500, E2502, E2504, E2506, E2508, E2510, E2811, E2512, E2599 A4606, A4608, A4615, A4617, A4619, A4620, E0424, E0425, E0439, E0440, E0441, E0442, E0447, E0550, E0560, E1352, E1353, E1354, E1355, E1357, E1358, E1330, E1391, E1392, E1399, E1405, E1406,	Neuromuscular Electrical Stimulation and Other Electrical Stimulator, MP-DE-1185 for additional requirements. For billed charges greater than \$500, prior authorization is required. Please refer to Home Apnea Monitors, MP-DE-1069 for additional requirements. For billed charges greater than \$500, prior authorization is required. Please refer to Home Dialysis Equipment and Supplies, MP-DE-1070 for additional requirements. For billed charges greater than \$500, prior authorization is required. Please refer to Speech Generating Devices, MP-DE-1077 for additional requirements. For billed charges greater than \$500, prior authorization is required. Please refer to Speech Generating Devices, MP-DE-1077 for additional requirements.
Stimulation and Other Electrical Stimulator Home Apnea Monitors Home Dialysis Equipment and Supplies Speech Generating Devices	A4595 E0745 E0764 E0770 E0618, E0619, E1933 A4245, A4653, A4657, A4660, A4663, A4670, A4671, A4672, A4673, A4674, A4728, A4927, A4930, E0210, E1510, E1520, E1530, E1540, E1550, E1560, E1570, E1575, E1580, E1590, E1592, E1594, E1600, E1610, E1615, E1620, E1625, E1630, E1632, E1634, E1635, E1636, E1699 E1902, E2500, E2502, E2504, E2506, E2508, E2510, E2511, E2512, E2599 A4606, A4608, A4615, A4616, A4617, A4619, A4620, E0424, E0425, E0439, E0440, E0441, E0442, E0447, E0550, E0560, E1352, E1333, E1334, E1355, E1357,	Neuromuscular Electrical Stimulation and Other Electrical Stimulator, MP-DE-1185 for additional requirements. For billed charges greater than \$500, prior authorization is required. Please refer to Home Apnea Monitors, MP-DE-1069 for additional requirements. For billed charges greater than \$500, prior authorization is required. Please refer to Home Dialysis Equipment and Supplies, MP-DE-1070 for additional requirements. For billed charges greater than \$500, prior authorization is required. Please refer to Speech Generating Devices, MP-DE-1077 for additional requirements. For billed charges greater than \$500, prior authorization is required. Please refer to Speech Generating Devices, MP-DE-1077 for additional requirements.
Stimulation and Other Electrical Stimulator Home Apnea Monitors Home Dialysis Equipment and Supplies Speech Generating Devices	A4595 E0745 E0776 E0776 E0618, E0619, E1933 A4245, M653, A4657, A4660, A4663, A4670, A4671, A4672, A4673, A4674, A4728, A4927, A4930, E0210, E1510, E1520, E1530, E1540, E1550, E1560, E1570, E1575, E1580, E1590, E1592, E1594, E1600, E1610, E1615, E1620, E1625, E1630, E1632, E1634, E1635, E1636, E1699 E1902, E2500, E2502, E2504, E2506, E2508, E2510, E2511, E2512, E2599 A4606, A4608, A4615, A4616, A4617, A4619, A4620, E0424, E0425, E0439, E0440, E0441, E0442, E0447, E0550, E0560, E1352, E1353, E1354, E1355, E1357, E1358, E1390, E1391, E1392, E1405, E1406, E0445, E0585, E0430, E0434, E0433, E0433, E0443,	Neuromuscular Electrical Stimulation and Other Electrical Stimulator, MP-DE-1185 for additional requirements. For billed charges greater than \$500, prior authorization is required. Please refer to Home Apnea Monitors, MP-DE-1069 for additional requirements. For billed charges greater than \$500, prior authorization is required. Please refer to Home Dialysis Equipment and Supplies, MP-DE-1070 for additional requirements. For billed charges greater than \$500, prior authorization is required. Please refer to Speech Generating Devices, MP-DE-1077 for additional requirements. For billed charges greater than \$500, prior authorization is required. Please refer to Speech Generating Devices, MP-DE-1077 for additional requirements.
Stimulation and Other Electrical Stimulator Home Apnea Monitors Home Dialysis Equipment and Supplies Speech Generating Devices Oxygen	A4595 E0745 E0776 E0776 E0618, E0619, E1933 A4245, M653, A4657, A4660, A4663, A4670, A4671, A4672, A4673, A4674, A4728, A4927, A4930, E0210, E1510, E1520, E1530, E1540, E1550, E1560, E1570, E1575, E1580, E1590, E1592, E1594, E1600, E1610, E1615, E1620, E1625, E1630, E1632, E1634, E1635, E1636, E1699 E1902, E2500, E2502, E2504, E2506, E2508, E2510, E2511, E2512, E2599 A4606, A4608, A4615, A4616, A4617, A4619, A4620, E0424, E0425, E0439, E0440, E0441, E0442, E0447, E0550, E0560, E1352, E1353, E1354, E1355, E1357, E1358, E1390, E1391, E1392, E1399, E1405, E1406, E0445, E0585, E0430, E0431, E0433, E0435, E0443, E0447, E1390, K0738	Neuromuscular Electrical Stimulation and Other Electrical Stimulator, MP-DE-1185 for additional requirements. For billed charges greater than \$500, prior authorization is required. Please refer to Home Apnea Monitors, MP-DE-1069 for additional requirements. For billed charges greater than \$500, prior authorization is required. Please refer to Home Dialysis Equipment and Supplies, MP-DE-1070 for additional requirements. For billed charges greater than \$500, prior authorization is required. Please refer to Speech Generating Devices, MP-DE-1077 for additional requirements. For billed charges greater than \$500, prior authorization is required. Please refer to Oxygen, MP-DE-1072 for additional requirements.
Stimulation and Other Electrical Stimulator Home Apnea Monitors Home Dialysis Equipment and Supplies Speech Generating Devices Oxygen	A4595 E0745 E0764 E0770 E0618, E0619, E1933 A4245, A4653, A4657, A4660, A4663, A4670, A4671, A4672, A4673, A4674, A4728, A4927, A4930, E0210, E1510, E1520, E1530, E1540, E1550, E1560, E1570, E1575, E1580, E1590, E1592, E1594, E1600, E1610, E1615, E1620, E1625, E1630, E1632, E1634, E1635, E1636, E1699 E1902, E2500, E2502, E2504, E2506, E2508, E2510, E2511, E2512, E2599 A4606, A4608, A4615, A4616, A4617, A4619, A4620, E0424, E0425, E0439, E0440, E0441, E0442, E0447, E1355, E1350, E1352, E1333, E1335, E1355, E1357, E1358, E1390, E1391, E1392, E1399, E1405, E1406, E0445, E0585, E0430, E0431, E0433, E0433, E0443, E0447, E1390, K0738	Neuromuscular Electrical Stimulation and Other Electrical Stimulator, MP-DE-1185 for additional requirements. For billed charges greater than \$500, prior authorization is required. Please refer to Home Apnea Monitors, MP-DE-1069 for additional requirements. For billed charges greater than \$500, prior authorization is required. Please refer to Home Dialysis Equipment and Supplies, MP-DE-1070 for additional requirements. For billed charges greater than \$500, prior authorization is required. Please refer to Speech Generating Devices, MP-DE-1077 for additional requirements. For billed charges greater than \$500, prior authorization is required. Please refer to Oxygen, MP-DE-1072 for additional requirements. For billed charges greater than \$500, prior authorization is required. Please refer to Oxygen, MP-DE-1072 for additional requirements.

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Security Production (1997) Control and Control (1997) Control and Control (1997) Control and Control (1997)	Enteral Feeding In-Line Catridge (EFIC)	B4105	For billed charges greater than \$500, prior authorization is required. Please refer to Enteral Feeding In-Line
Self-Authority (1994) 2015 - 1995 -	Transcutaneous Transducer Garments	E0731	For billed charges greater than \$500, prior authorization is required. Please refer to Transcutaneous
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Society Annaba (2017), 2028, APSS, A	Home Pulse Oximetry Devices	EU445, A4606	
Modern (Modern Control) Modern (Modern Contro			For billed charges greater than \$500, prior authorization is required. Please refer to Devices Used for the Treatment of Obstructive Sleep Apnea in Adults, MP-DE-1063 for additional requirements.
MOSIL APORE, APORE, (2015, 1921, 192		A7047, E0561, E0562, E0600	
Control control control of the institute of the property of th	Respiratory Assist Devices	A7033, A7034, A7035, A7036, A7037, A7038, A7039, A7044, A7045, A7046, E0470, E0471, E0472, E0561,	
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Fine alternation was, recluding presumed. STORT	Home delivered meals, including preparation;	S5170-U1	Prior authorization is required. Coverage is limited to two meals per day for DSHP+LTSS members.
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MRITMJ 70336 Prior Authorization goes through eviCore	MRITMJ	70336	Prior Authorization goes through eviCore

C T Head Without Contrast	70450	Prior Authorization goes through eviCore
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CT Head Without & With Contrast	70470	Prior Authorization goes through eviCore
CT Orbit Without Contrast	70480	Prior Authorization goes through eviCore
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Contrast		
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C T Soft Tissue Neck With Contrast	70491	Prior Authorization goes through eviCore
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C T Angiography Head	70496	Prior Authorization goes through autCore
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MRI Orbit, Face, and/or Neck Without	70540	Prior Authorization goes through eviCore
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MRI Face, Orbit, and/or Neck With	70542	Prior Authorization goes through eviCore
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M R A Head Without Contrast	70544	Prior Authorization goes through eviCore
M R A Head With Contrast	70545	Prior Authorization goes through eviCore
MRA Head With & Without Contrast	70546	Prior Authorization goes through eviCore
M R A Neck Without Contrast	70547	Prior Authorization goes through eviCore
M R A Neck With Contrast	70548	Prior Authorization goes through eviCore
M R A Neck With & Without Contrast	70549	Prior Authorization goes through eviCore
M R I Head Without Contrast	70551	Prior Authorization goes through eviCore
M R I Head With Contrast	70552	Prior Authorization goes through eviCore
M R I Head With & Without Contrast	70553	Prior Authorization goes through eviCore
MRI Brain, functional MRI	70554	Prior Authorization goes through eviCore
MRI Brain, functional MRI, requiring	70555	Prior Authorization goes through evicore Prior Authorization goes through evicore
physician	, , , , , , , , , , , , , , , , , , , ,	. not rection taken goes timough exicore
7 7	71250	Prior Authorization goes through eviCore
CTThorax With Contrast	. ====	Prior Authorization goes through eviCore
CTThorax With Contrast	71260	Prior Authorization goes through eviCore
C T Thorax Without & With Contrast	71270	Prior Authorization goes through eviCore
CT Angiography Chest Without Contrast	71275	Prior Authorization goes through eviCore
Material, Followed by Contrast Material		
and Further Sections, Including Image		
Postprocessing		
MRI Chest Without Contrast	71550	Prior Authorization goes through eviCore
M R I Chest With Contrast	71551	Prior Authorization goes through eviCore
MRI Chest With & Without Contrast	71552	Prior Authorization goes through eviCore
M R A Chest (Excluding Myocardium) With		Prior Authorization goes through eviCore
Or Without Contrast	71333	Thoi Authorization goes through evictore
C T Cervical Spine Without Contrast	72125	Prior Authorization goes through eviCore
	-	
C T Cervical Spine With Contrast	72126	Prior Authorization goes through eviCore
CT Cervical Spine Without & With	72127	Prior Authorization goes through eviCore
Contrast		
C T Thoracic Spine Without Contrast	72128	Prior Authorization goes through eviCore
C T Thoracic Spine With Contrast	72129	Prior Authorization goes through eviCore
C T Thoracic Spine Without & With	72130	Prior Authorization goes through eviCore
		* *
Contrast		
	72131	Prior Authorization goes through eviCore
Contrast		
Contrast CTLumbar Spine Without Contrast	72131	Prior Authorization goes through eviCore
Contrast CTLumbar Spine Without Contrast CTLumbar Spine With Contrast	72131 72132	Prior Authorization goes through eviCore Prior Authorization goes through eviCore
CONTrast CTLumbar Spine Without Contrast CTLumbar Spine With Contrast CTLumbar Spine Without & With	72131 72132	Prior Authorization goes through eviCore Prior Authorization goes through eviCore
Contrast CTLumbar Spine Without Contrast CTLumbar Spine With Contrast CTLumbar Spine Without & With Contrast	72131 72132 72133	Prior Authorization goes through eviCore
Contrast CTLumbar Spine Without Contrast CTLumbar Spine With Contrast CTLumbar Spine Without & With Contrast MRI Cervical Spine Without Contrast MRI Cervical Spine With Contrast	72131 72132 72133 72141 72142	Prior Authorization goes through eviCore
Contrast CTLumbar Spine Without Contrast CTLumbar Spine With Contrast CTLumbar Spine Without & With Contrast MRI Cervical Spine Without Contrast MRI Cervical Spine With Contrast MRI Toracic Spine With Contrast	72131 72132 72132 72133 72141 72142 72146	Prior Authorization goes through eviCore
Contrast CTLumbar Spine Without Contrast CTLumbar Spine With Contrast CTLumbar Spine Without & With Contrast MRICervical Spine Without Contrast MRI Cervical Spine With Contrast MRI Thoracic Spine Without Contrast MRI Thoracic Spine With Contrast	72131 72132 72133 72141 72142 72146 72147	Prior Authorization goes through eviCore
Contrast CTLumbar Spine Without Contrast CTLumbar Spine With Contrast CTLumbar Spine Without & With Contrast MRI Cervical Spine Without Contrast MRI Cervical Spine With Contrast MRI Thoracic Spine With Contrast MRI Thoracic Spine With Contrast MRI Lambar Spine Without Contrast	72131 72132 72133 72141 72142 72146 72147 72147	Prior Authorization goes through eviCore
Contrast CTLumbar Spine Without Contrast CTLumbar Spine With Contrast CTLumbar Spine Without & With Contrast MRI Cervical Spine Without Contrast MRI Toracia Spine With Contrast MRI Thoracia Spine With Contrast MRI Thoracia Spine With Contrast MRI Thoracia Spine With Contrast MRI Lumbar Spine With Contrast MRI Lumbar Spine With Contrast	72131 72132 72133 72141 72142 72146 72147 72148 72148	Prior Authorization goes through eviCore
Contrast CTLumbar Spine Without Contrast CTLumbar Spine With Contrast CTLumbar Spine With Contrast CTLumbar Spine Without & With Contrast MRI Cervical Spine Without Contrast MRI Thoracic Spine With Contrast MRI Thoracic Spine With Contrast MRI Lumbar Spine With Contrast MRI Lumbar Spine With Contrast MRI Lumbar Spine With Contrast	72131 72132 72133 72141 72142 72146 72147 72147	Prior Authorization goes through eviCore
Contrast CTLumbar Spine Without Contrast CTLumbar Spine With Contrast CTLumbar Spine Without & With Contrast MRI Cervical Spine Without Contrast MRI Cervical Spine With Contrast MRI Thoracic Spine With Contrast MRI Thoracic Spine With Contrast MRI Lumbar Spine Without Contrast MRI Lumbar Spine With Contrast MRI Contrast MRI Cervical Spine With Contrast MRI Cervical Spine With Contrast Contrast	72131 72132 72133 72141 72142 72146 72147 72148 72149 72156	Prior Authorization goes through eviCore
Contrast CTLumbar Spine Without Contrast CTLumbar Spine With Contrast CTLumbar Spine Without & With Contrast MRI Cervical Spine Without Contrast MRI Cervical Spine Without Contrast MRI Thoracic Spine Without Contrast MRI Thoracic Spine With Contrast MRI Lumbar Spine With Contrast MRI Cervical Spine Without Contrast MRI Cervical Spine Without Contrast MRI Cervical Spine With Contrast MRI Cervical Spine With Without Contrast MRI Toracic Spine With & Without	72131 72132 72133 72141 72142 72146 72147 72148 72148	Prior Authorization goes through eviCore
Contrast CTLumbar Spine Without Contrast CTLumbar Spine With Contrast CTLumbar Spine With Contrast CTLumbar Spine Without & With Contrast MRI Cervical Spine Without Contrast MRI Toracic Spine With Contrast MRI Thoracic Spine With Contrast MRI Lumbar Spine With Contrast MRI Lumbar Spine With Contrast MRI Cervical Spine With Contrast MRI Thoracic Spine With & Without Contrast MRI Thoracic Spine With & Without Contrast	72131 72132 72133 72141 72142 72146 72147 72148 72149 72156	Prior Authorization goes through eviCore
Contrast CTLumbar Spine Without Contrast CTLumbar Spine With Contrast CTLumbar Spine Without & With Contrast MRI Cervical Spine Without Contrast MRI Cervical Spine With Contrast MRI Thoracic Spine With Contrast MRI Thoracic Spine With Contrast MRI Lumbar Spine With Contrast MRI Lumbar Spine With Contrast MRI Contrast MRI Cervical Spine With Contrast MRI Thoracic Spine With Contrast MRI Thoracic Spine With Contrast MRI Thoracic Spine With & Without Contrast MRI Thoracic Spine With & Without Contrast	72131 72132 72133 72141 72142 72146 72147 72148 72149 72156	Prior Authorization goes through eviCore
Contrast CTLumbar Spine Without Contrast CTLumbar Spine With Contrast CTLumbar Spine With Contrast CTLumbar Spine Without & With Contrast MRICervical Spine Without Contrast MRIThoracic Spine Without Contrast MRIThoracic Spine Without Contrast MRIThoracic Spine With Contrast MRIThoracic Spine With Contrast MRICervical Spine With Contrast MRICervical Spine Without Contrast MRICERVICAL Spine With Without Contrast MRITHORACIC Spine With & Without Contrast MRILUmbar Spine With & Without Contrast MRILUmbar Spine With & Without Contrast	72131 72132 72133 72141 72142 72146 72147 72148 72149 72156 72157	Prior Authorization goes through eviCore
Contrast CTLumbar Spine Without Contrast CTLumbar Spine With Contrast CTLumbar Spine With Contrast CTLumbar Spine Without & With Contrast MRI Cervical Spine Without Contrast MRI Thoracic Spine With Contrast MRI Thoracic Spine With Contrast MRI Lumbar Spine Without Contrast MRI Lumbar Spine Without Contrast MRI Lumbar Spine Without Contrast MRI Thoracic Spine With Contrast MRI Thoracic Spine With Contrast MRI Lumbar Spine Without Contrast MRI Lumbar Spine Without Contrast MRI Lumbar Spine Without Contrast MRI Lumbar Spine With & Without Contrast MRI Lumbar Spine With & Without Contrast MRI Spine With & Without Contrast	72131 72132 72133 72141 72142 72146 72147 72148 72149 72156	Prior Authorization goes through eviCore
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Contrast CTLumbar Spine Without Contrast CTLumbar Spine With Contrast CTLumbar Spine With Contrast CTLumbar Spine Without & With Contrast MRICervical Spine Without Contrast MRI Thoracic Spine Without Contrast MRI Thoracic Spine With Contrast MRI Thoracic Spine With Contrast MRI Lumbar Spine With Contrast MRI Cervical Spine Without Contrast MRI Cervical Spine With Without Contrast MRI Cervical Spine With & Without Contrast MRI Lumbar Spine With Without Contrast MRI Lumbar Spine With & Without Contrast MRI Contrast MRI Contrast CTAngiography Pelvis	72131 72132 72133 72141 72142 72146 72147 72148 72156 72157 72158 72159	Prior Authorization goes through eviCore
Contrast CTLumbar Spine Without Contrast CTLumbar Spine With Contrast CTLumbar Spine Without & With Contrast MRI Cervical Spine Without Contrast MRI Cervical Spine With Contrast MRI Thoracic Spine With Contrast MRI Thoracic Spine With Contrast MRI Lumbar Spine With Contrast MRI Lumbar Spine With Contrast MRI Lumbar Spine With Contrast MRI Cervical Spine With Contrast MRI Contrast MRI Thoracic Spine With & Without Contrast MRI Thoracic Spine With & Without Contrast MRI MRI Without Contrast	72131 72132 72133 72141 72142 72146 72147 72148 72149 72156 72157 72158 72159 72191	Prior Authorization goes through eviCore
Contrast CTLumbar Spine Without Contrast CTLumbar Spine With Contrast CTLumbar Spine Without & With Contrast MRI Cervical Spine Without Contrast MRI Cervical Spine Without Contrast MRI Thoracic Spine Without Contrast MRI Thoracic Spine With Contrast MRI Contrast Contrast MRI Contrast MRI Contrast Contras	72131 72132 72133 72141 72142 72146 72147 72148 72149 72156 72157 72158	Prior Authorization goes through eviCore
Contrast CTLumbar Spine Without Contrast CTLumbar Spine With Contrast CTLumbar Spine With Contrast CTLumbar Spine Without & With Contrast M R I Cervical Spine With Contrast M R I Cervical Spine With Contrast M R I Thoracic Spine With Contrast M R I Thoracic Spine With Contrast M R I Lumbar Spine With Contrast M R I Curvical Spine With Contrast M R I Lumbar Spine With Ontrast M R I Lumbar Spine With Outrast M R I Lumbar Spine With Outrast M R I Thoracic Spine With & Without Contrast M R I Thoracic Spine With & Without Contrast M R I Spinal Canal With Or Without Contrast CT Angiography Pelvis CT Pelvis Without Contrast CT Pelvis With Contrast CT Pelvis With Contrast CT Pelvis With Contrast CT Pelvis With Contrast	72131 72132 72133 72141 72142 72146 72147 72148 72148 72156 72157 72158 72159 72191 72192 72193 72194	Prior Authorization goes through eviCore
Contrast CTLumbar Spine Without Contrast CTLumbar Spine With Contrast CTLumbar Spine With Contrast CTLumbar Spine Without & With Contrast MRI Cervical Spine Without Contrast MRI Thoracic Spine With Contrast MRI Thoracic Spine With Contrast MRI Thoracic Spine With Contrast MRI Lumbar Spine With Contrast MRI Cervical Spine With Contrast MRI Cervical Spine With Contrast MRI Contrast MRI Contrast MRI Contrast Contrast Contrast MRI Contrast MRI Contrast Contrast Contrast MRI Contrast Contrast MRI Contrast Contrast MRI Contrast CONTRAST CONTRAST MRI CONTRAST CONTRAST CONTRAST CT Pelvis Without Contrast	72131 72131 72132 72133 72141 72142 72146 72147 72148 72149 72156 72157 72158 72159 72191 72191 72192 72193 72194 72195	Prior Authorization goes through eviCore
Contrast CTLumbar Spine Without Contrast CTLumbar Spine With Contrast CTLumbar Spine With Contrast CTLumbar Spine Without & With Contrast MRI Cervical Spine Without Contrast MRI Corvical Spine Without Contrast MRI Thoracic Spine Without Contrast MRI Thoracic Spine With Contrast MRI Contrast MRI Contrast MRI Lumbar Spine With Contrast MRI Lumbar Spine With Outrast MRI Lumbar Spine With Outrast MRI Lumbar Spine With Without Contrast MRI Corvical Spine With & Without Contrast MRI Corvical Spine With & Without Contrast Contrast MRI Contrast Contrast MRI Contrast CTPelvis Without Contrast CTPelvis Without Contrast CTPelvis With Contrast CTPelvis With Contrast CTPelvis With Contrast MRI Pelvis Without Contrast MRI Pelvis Without Contrast MRI Pelvis Without Contrast MRI Pelvis With Contrast	72131 72132 72133 72141 72142 72146 72147 72148 72149 72156 72157 72159 72191 72192 72193 72194 72195 72195 72195 72195	Prior Authorization goes through eviCore
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Contrast CTLumbar Spine Without Contrast CTLumbar Spine With Contrast CTLumbar Spine With Contrast CTLumbar Spine Without & With Contrast MRI Cervical Spine Without Contrast MRI Corevical Spine Without Contrast MRI Thoracic Spine Without Contrast MRI Thoracic Spine Without Contrast MRI Corevical Spine With Contrast MRI Corevical Spine With Contrast MRI Contrast MRI Corevical Spine With Without Contrast MRI Corevical Spine With & Without Contrast MRI Corevical Spine With & Without Contrast MRI Corevical Spine With & Without Contrast CT Pelvis Without Contrast CT Pelvis With Contrast CT Pelvis With Contrast MRI Pelvis With Contrast	72131 72131 72132 72133 72141 72142 72146 72147 72148 72149 72156 72157 72158 72159 72191 72192 72191 72192 72193 72194 72195 72196 72196 72197	Prior Authorization goes through eviCore
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Contrast CTLumbar Spine Without Contrast CTLumbar Spine With Contrast CTLumbar Spine With Contrast CTLumbar Spine Without & With Contrast MR I Cervical Spine Without Contrast MR I Charcia Spine With Contrast MR I Thoracia Spine With Contrast MR I Thoracia Spine With Contrast MR I Lumbar Spine With Contrast MR I Lumbar Spine With & Without Contrast MR I Lumbar Spine With & Without Contrast MR I Lumbar Spine With & Without Contrast MR I Pelvis Without Contrast CT Pelvis Without Contrast CT Pelvis Without Contrast MR I Pelvis With & Without Contrast MR I Pelvis With With Without Contrast CT Upper Extremity Without Contrast CT Upper Extremity Without & With Contrast CT Upper Extremity Without & With Contrast CT Upper Extremity Without & With Contrast CT Longiography Upper Extremity CT Angiography Upper Extremity	72131 72131 72132 72133 72141 72142 72146 72147 72148 72149 72155 72157 72158 72159 72191 72192 72193 72194 72195 72197 72198 73200 73200	Prior Authorization goes through eviCore
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Contrast CT Lumbar Spine Without Contrast CT Lumbar Spine With Contrast CT Lumbar Spine With Contrast CT Lumbar Spine Without & With Contrast MR I Cervical Spine Without Contrast MR I Cervical Spine With Contrast MR I Thoracic Spine With Contrast MR I Thoracic Spine With Contrast MR I Lumbar Spine With Contrast MR I Lumbar Spine With Contrast MR I Cervical Spine With Contrast MR I Cumbar Spine With Without Contrast MR I Contrast MR I Cervical Spine With & Without Contrast MR I Spine With & Without Contrast MR I Candar Spine With & Without Contrast Contrast MR I Pelvis With Contrast CT Pelvis Without Contrast CT Pelvis Without Contrast MR I Pelvis With & Without Contrast MR I Pelvis With Without Contrast MR I Pelvis With Without Contrast CT Upper Extremity Without Contrast CT Upper Extremity Without A With Contrast CT Angiography Upper Extremity MR I Upper Extremity Without Contrast CT Angiography Upper Extremity MR I Upper Extremity With S Without	72131 72131 72132 72133 72141 72142 72146 72147 72148 72149 72156 72157 72158 72159 72191 72192 72193 72194 72196 72197 72198 72199 72191 72192 72193 72194 72195 72196 72197 72198 73200 73206 73206	Prior Authorization goes through eviCore
Contrast CTLumbar Spine Without Contrast CTLumbar Spine With Contrast CTLumbar Spine With Contrast CTLumbar Spine Without & With Contrast MRI Cervical Spine Without Contrast MRI Cervical Spine With Contrast MRI Thoracic Spine With Contrast MRI Thoracic Spine With Contrast MRI Lumbar Spine Without Contrast Contrast MRI Lumbar Spine With & Without Contrast Contrast MRI Lumbar Spine With Swithout Contrast CT Pelvis With Contrast CT Anglography Pelvis CT Pelvis With Contrast MRI Pelvis With Contrast CT Upper Extremity With Contrast MRI Upper Extremity With Contrast	72131 72131 72132 72133 72141 72142 72146 72147 72148 72149 72156 72157 72158 72159 72191 72192 72193 72194 72195 72197 72198 72197 72198 72197 72198 72197 72198 72197 72198 72197 72198 72197 72198 72200	Prior Authorization goes through eviCore Prior Authorization goes through eviC
Contrast CT Lumbar Spine Without Contrast CT Lumbar Spine With Contrast CT Lumbar Spine With Contrast CT Lumbar Spine Without & With Contrast MR I Cervical Spine Without Contrast MR I Cervical Spine With Contrast MR I Thoracic Spine With Contrast MR I Thoracic Spine With Contrast MR I Lumbar Spine With Contrast MR I Lumbar Spine With Contrast MR I Cervical Spine With Contrast MR I Contrast MR I Cervical Spine With & Without Contrast MR I Contrast MR I Cervical Spine With & Without Contrast Contrast MR I Lumbar Spine With & Without Contrast CT Angiography Pelvis CT Pelvis Without Contrast CT Pelvis Without Contrast MR I Pelvis Without Contrast CT Pelvis With With Without Contrast CT Upper Extremity Without Contrast CT Upper Extremity Without Contrast CT Upper Extremity Without Contrast CT Angiography Upper Extremity MR I Upper Extremity Without Contrast MR I Upper Extremity With Contrast MR I Upper Extremity Without Contrast MR I Upper Extremity Without Contrast	72131 72131 72132 72133 72141 72142 72146 72147 72148 72149 72156 72157 72158 72191 72191 72192 72191 72193 72194 72195 72198 72197 72198 72198 72200 73200 73200 73206 73218	Prior Authorization goes through eviCore
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Contrast CTLumbar Spine Without Contrast CTLumbar Spine With Contrast CTLumbar Spine With Contrast CTLumbar Spine With Contrast MR I Cervical Spine Without & With Contrast MR I Cervical Spine With Contrast MR I Thoracic Spine With Contrast MR I Thoracic Spine With Contrast MR I Lumbar Spine With Contrast MR I Lumbar Spine With Contrast MR I Polivis Without Contrast MR I Pelvis With Without Contrast MR I Upper Extremity Without Contrast CT Upper Extremity Without With Contrast CT Angiography Upper Extremity MR I Upper Extremity Without Contrast MR I Upper Extremity With Contrast MR I Upper Extremity Without Contrast MR I Upper Extremity Without Without Contrast	72131 72131 72132 72133 72141 72142 72146 72147 72148 72149 72156 72157 72158 72159 72191 72192 72193 72194 72195 72196 72197 72198 72190 72191 72192 72193 72194 72195 72196 72197 72198 72200 73200 73201 73202	Prior Authorization goes through eviCore Prior Authorization goes through eviC
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assessment of cardiac function, and evaluation of venous structures, if performed) 75573 Prior Authorization goes through eviCore			
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Computed tomographic angiography, heart, coronary arteries and bypass grafts (when present), with contrast material, including 3d image postprocessing (including evaluation of cardiac structure and morphology, assessment of cardiac function, and evaluation of venous structures, if performed) CT Angiography Abdominal Aorta 75635 Prior Authorization goes through eviCore Prior Authorization goes through eviCore	and function and evaluation of vascular		
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including 3d image postprocessing (including evaluation of cardiac structure and morphology, assessment of cardiac function, and evaluation of venous structures, if performed) CT Angiography Abdominal Aorta 75635 Prior Authorization goes through eviCore 3D Rendering W/O Postprocessing 76376 Prior Authorization goes through eviCore	heart, coronary arteries and bypass grafts		
(Including evaluation of cardiac structure and morphology, assessment of cardiac function, and evaluation of venous structures, if performed) CT Angiography Abdominal Aorta 75635 Prior Authorization goes through eviCore 3D Rendering W/O Postprocessing 76376 Prior Authorization goes through eviCore			
and morphology, assessment of cardiac function, and evaluation of venous structures, if performed) CT Angiography Abdominal Aorta 75635 Prior Authorization goes through eviCore 3D Rendering W/O Postprocessing 76376 Prior Authorization goes through eviCore			
function, and evaluation of venous structures, if performed) CT Angiography Abdominal Aorta 75635 Prior Authorization goes through eviCore 3D Rendering W/O Postprocessing 76376 Prior Authorization goes through eviCore			
structures, if performed) CT Angiography Abdominal Aorta 75635 Prior Authorization goes through eviCore 30 Rendering W/O Postprocessing 76376 Prior Authorization goes through eviCore			
3D Rendering W/O Postprocessing 76376 Prior Authorization goes through eviCore			
3D Rendering W/O Postprocessing 76376 Prior Authorization goes through eviCore	1		
3D Rendering W Postprocessing 76377 Prior Authorization goes through eviCore			
		76377	Prior Authorization goes through eviCore

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CT Limited Or Localized Follow-Up Study	76380	Prior Authorization goes through eviCore
MRISpectroscopy	76390	Prior Authorization goes through eviCore
Magnetic resonance (eg, vibration)	76391	Prior Authorization goes through eviCore
elastography		, , , , , , , , , , , , , , , , , , ,
MRI Guidance For Needle Placement	77021	Prior Authorization goes through eviCore
Magnetic resonance guidance for, and	77022	Prior Authorization goes through eviCore
monitoring of, parenchymal tissue ablation		
	77046	Prior Authorization goes through wiCore
Magnetic resonance imaging, breast, without contrast material; unilateral	77046	Prior Authorization goes through eviCore
Magnetic resonance imaging, breast,	77047	Prior Authorization goes through eviCore
without contrast material; bilateral		, , , , , , , , , , , , , , , , , , ,
Magnetic resonance imaging, breast,	77048	Prior Authorization goes through eviCore
without and with contrast material(s),		
including computer-aided detection (CAD real-time lesion detection,		
characterization and pharmacokinetic		
analysis), when performed; unilateral		
Magnetic resonance imaging, breast,	77049	Prior Authorization goes through eviCore
without and with contrast material(s),		· · ·
including computer-aided detection (CAD		
real-time lesion detection,		
characterization and pharmacokinetic analysis), when performed; bilateral		
Computed Tomography, bone mineral	77078	Prior Authorization goes through eviCore
density study, 1 or more sites; axial	77078	Filor Authorization goes through evicore
skeleton		
Magnetic resonance (eg, proton) imaging,	77084	Prior Authorization goes through eviCore
bone marrow blood supply		
Thyroid uptake, single or multiple	78012	Prior Authorization goes through eviCore
quantitative measurement(s) (including		
stimulation, suppression, or discharge, when performed)		
Thyroid imaging (including vascular flow,	78013	Prior Authorization goes through eviCore
when performed)		
Thyroid imaging (including vascular flow,	78014	Prior Authorization goes through eviCore
when performed); with single or multiple		
uptake(s) quantitative measurement(s)		
(including stimulation, suppression, or		
discharge, when performed)		
Thyroid Met Imaging	78015	Prior Authorization goes through eviCore
Thyroid Met Imaging With Additional	78016	Prior Authorization goes through evicore Prior Authorization goes through eviCore
Studies	70010	Thornation goest model execute
Thyroid Scan Whole Body	78018	Prior Authorization goes through eviCore
Thyroid Carcinoma Metastases Uptake	78020	Prior Authorization goes through eviCore
Parathyroid planar imaging (including	78070	Prior Authorization goes through eviCore
subtraction, when performed)	70074	
Parathyroid planar imaging (including subtraction, when performed); with	78071	Prior Authorization goes through eviCore
tomographic (SPECT)		
Parathyroid planar imaging (including	78072	Prior Authorization goes through eviCore
subtraction, when performed); with		
tomographic (SPECT), and concurrently		
acquired computed tomography (CT) for anatomical localization		
	78075	Daine Anthonisetics acceptance by aniform
Adrenal Nuclear Imaging Bone Marrow Imaging, Limited	78102	Prior Authorization goes through eviCore Prior Authorization goes through eviCore
Bone Marrow Imaging, Multiple	78103	Prior Authorization goes through eviCore
Bone Marrow Imaging, Whole Body	78104	Prior Authorization goes through eviCore
Labeled Red Cell Sequestration	78140	Prior Authorization goes through eviCore
Spleen Imaging With & Without Vascular	78185	Prior Authorization goes through eviCore
Flow	70105	Drier Authorization goes through miCore
Lymph System Imaging	78195 78201	Prior Authorization goes through eviCore
Liver Imaging Liver Imaging With Flow	78201 78202	Prior Authorization goes through eviCore Prior Authorization goes through eviCore
Liver & Spleen Imaging	78215	Prior Authorization goes through evicore Prior Authorization goes through eviCore
Liver & Spleen Imaging Liver & Spleen Imaging With Flow	78216	Prior Authorization goes through eviCore
Hepatobiliary system imaging, including	78226	Prior Authorization goes through eviCore
gallbladder when present;		
Hepatobiliary system imaging, including	78227	Prior Authorization goes through eviCore
gallbladder when present; with pharmacologic intervention, including		
quantitative measurement(s) when		
performed		
Salivary Gland Imaging	78230	Prior Authorization goes through eviCore
Serial Salivary Gland	78231	Prior Authorization goes through eviCore
Salivary Gland Function Exam	78232	Prior Authorization goes through eviCore
Esophogus Motility Study	78258	Prior Authorization goes through eviCore
Gastric Mucosa Imaging	78261	Prior Authorization goes through eviCore
Gastric Emptying Study	78262 78264	Prior Authorization goes through eviCore Prior Authorization goes through eviCore
Gastric Emptying Study	78265	Prior Authorization goes through evicore Prior Authorization goes through eviCore
Gastric emptying imaging study leg colid		
Gastric emptying imaging study (eg, solid, liquid, or both); with small bowel transit		
liquid, or both); with small bowel transit Gastric emptying imaging study (eg, solid,	78266	Prior Authorization goes through eviCore
liquid, or both); with small bowel transit Gastric emptying imaging study (eg, solid, liquid, or both); with small bowel and		Prior Authorization goes through eviCore
liquid, or both); with small bowel transit Gastric emptying imaging study (eg, solid, liquid, or both); with small bowel and colon transit, multiple days	78266	
liquid, or both); with small bowel transit Gastric emptying imaging study (eg, solid, liquid, or both); with small bowel and colon transit, multiple days GI Bleeder Scan	78278	Prior Authorization goes through eviCore
liquid, or both); with small bowel transit Gastric emptying imaging study (eg, solid, liquid, or both); with small bowel and colon transit, multiple days Gi Bleeder Scan Meckels Diverticulum Imaging	78266 78278 78290	Prior Authorization goes through eviCore Prior Authorization goes through eviCore
liquid, or both); with small bowel transit Gastric emptying imaging study (eg. solid, liquid, or both); with small bowel and colon transit, multiple days Gi Bleeder Scan Meckels Diverticulum Imaging Leveen Shunt Patency Exam	78266 78278 78290 78291	Prior Authorization goes through eviCore Prior Authorization goes through eviCore Prior Authorization goes through eviCore
liquid, or both); with small bowel transit Gastric emptying imaging study (eg, solid, liquid, or both); with small bowel and colon transit, multiple days Gi Bleeder Scan Meckels Diverticulum Imaging Leveen Shunt Patency Exam Bone Or Joint Imaging Limited	78278 78290 78291 78300	Prior Authorization goes through eviCore
liquid, or both); with small bowel transit Gastric emptying imaging study (eg. solid, liquid, or both); with small bowel and colon transit, multiple days Gi Bleeder Scan Meckels Diverticulum Imaging Leveen Shunt Patency Exam	78266 78278 78290 78291	Prior Authorization goes through eviCore Prior Authorization goes through eviCore Prior Authorization goes through eviCore
liquid, or both); with small bowel transit Gastric emptying imaging study (eg, solid, liquid, or both); with small bowel and colon transit, multiple days Gi Bleeder Scan Meckels Diverticulum Imaging Leveen Shunt Patency Exam Bone Or Joint Imaging Limited Bone Or Joint Imaging Multiple	78278 78290 78291 78300 78305	Prior Authorization goes through eviCore
liquid, or both); with small bowel transit Gastric emptying imaging study (eg, solid, liquid, or both); with small bowel and colon transit, multiple days Gi Bleeder Scan Meckels Diverticulum Imaging Leveen Shunt Patency Exam Bone Or Joint Imaging Imited Bone Or Joint Imaging Multiple Bone Scan Whole Body Bone Scan Phase Study Non-Imaging Heart Function	78278 78290 78291 78300 78305 78315 78315	Prior Authorization goes through eviCore
liquid, or both); with small bowel transit Gastric emptying imaging study (eg. solid, liquid, or both), with small bowel and colon transit, multiple days GI Bleeder Scan Meckels Diverticulum Imaging Leveen Shunt Patency Exam Bone Or Joint Imaging Ilmited Bone Or Joint Imaging Multiple Bone Scan Whole Body Bone Scan 3 Phase Study	78278 78290 78291 78300 78305 78306 78315	Prior Authorization goes through eviCore

Myocardial imaging, positron emission	T	
	78429	Prior Authorization goes through eviCore
tomography (PET), metabolic evaluation		
study (including ventricular wall		
motion[s] and/or ejection fraction[s], when performed), single study; with		
concurrently acquired computed		
tomography transmission scan		
Myocardial imaging, positron emission	78430	Prior Authorization goes through eviCore
tomography (PET), perfusion study	70430	The Nationality goesting greaters
(including ventricular wall motion[s]		
and/or ejection fraction[s], when		
performed); single study, at rest or stress		
(exercise or pharmacologic), with		
concurrently acquired computed		
tomography transmission scan		
Myocardial imaging, positron emission	78431	Prior Authorization goes through eviCore
tomography (PET), perfusion study		
(including ventricular wall motion[s]		
and/or ejection fraction[s], when performed); multiple studies at rest and		
stress (exercise or pharmacologic), with		
concurrently acquired computed		
tomography transmission scan		
Myocardial imaging, positron emission	78432	Prior Authorization goes through eviCore
tomography (PET), combined perfusion		
with metabolic evaluation study		
(including ventricular wall motion[s]		
and/or ejection fraction[s], when		
performed), dual radiotracer (eg, myocardial viability);		
* **	70400	
Myocardial imaging, positron emission tomography (PET), combined perfusion	78433	Prior Authorization goes through eviCore
with metabolic evaluation study		
(including ventricular wall motion[s]		
and/or ejection fraction[s], when		
performed), dual radiotracer (eg,		
myocardial viability); with concurrently		
acquired computed tomography transmission scan		
Absolute quantitation of myocardial	78434	Prior Authorization goes through eviCore
blood flow (AQMBF), positron emission tomography (PET), rest and		
pharmacologic stress (List separately in		
addition to code for primary procedure)		
Radionuclide Venogram Non-Cardiac	78445	Prior Authorization goes through eviCore
78451 myocardial perfusion imaging,	78451	Prior Authorization goes through eviCore
tomographic (spect) including		
attenuation correction, qualitative or		
quantitative wall motion, ejection fraction by first pass or gated technique,		
additional quantification, when		
performed); single study, at rest or stress		
(exercise or pharmacologic)		
Myocardial perfusion imaging,	78452	Prior Authorization goes through eviCore
tomographic (spect) (including		
attenuation correction, qualitative or		
quantitative wall motion, ejection		
fraction by first pass or gated technique,		
additional quantification, when		
additional quantification, when performed); multiple studies, at rest		
additional quantification, when		
additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic)		
additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection	78453	Prior Authorization goes through eviCore
additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest	78453	Prior Authorization goes through eviCore
additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or	78453	Prior Authorization goes through eviCore
additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional	78453	Prior Authorization goes through eviCore
additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); single	78453	Prior Authorization goes through eviCore
additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); single study, at rest or stress (exercise or	78453	Prior Authorization goes through eviCore
additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); single study, at rest or stress (exercise or pharmacologic)		
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additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); single study, at rest or stress (exercise or pharmacologic) Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or		
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additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); single study, at rest or stress (exercise or pharmacologic) Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection Acute Venous Thrombosis Imaging Unilateral Venous Thrombosis Imaging Unilateral Venous Thrombosis Imaging Unilateral	78454 78456 78457	Prior Authorization goes through eviCore Prior Authorization goes through eviCore Prior Authorization goes through eviCore
additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); single study, at rest or stress (exercise or pharmacologic) Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection Acute Venous Thrombosis Imaging Unilateral Venous Thrombosis Imaging Unilateral Myocardial imaging, positron emission tomography (PET), metabolic evaluation	78454 78456 78457 78458	Prior Authorization goes through eviCore Prior Authorization goes through eviCore Prior Authorization goes through eviCore Prior Authorization goes through eviCore
additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); single study, at rest or stress (exercise or pharmacologic) Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection Acute Venous Thrombosis Imaging Unilateral Venous Thrombosis Imaging Unilateral Myocardial imaging, positron emission tomography (PET), metabolic evaluation study (including ventricular wall	78454 78456 78457 78458	Prior Authorization goes through eviCore Prior Authorization goes through eviCore Prior Authorization goes through eviCore Prior Authorization goes through eviCore
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acquistion, interpretation and report only 3D echocardiographic imaging and postprocessing during transesophageal echocardiography, or during transthoracic echocardiography for congenital cardiac anomalies, for the assessment of cardiac structure(s) (eg. cardiac chambers and valves, left atrial appendage, interatrial septum, interventricular septum) and function, when performed (List separately in addition to code for echocardiographic imaging Doppler echocardiography, pulsed wave and/or continuous wave with spectral display; complete Doppler echocardiography, pulsed wave and/or continuous wave with spectral display; complete Doppler echocardiography, pulsed wave and/or continuous wave with spectral display; follow-up or limited study Doppler echocardiography (pulsed wave and/or continuous wave with spectral display; follow-up or limited study) Prior Authorization goes through eviCore			· · · · · · · · · · · · · · · · · · ·
only 3D echocardiographic imaging and postprocessing during transesophageal echocardiography or during transtoracic echocardiography for congenital cardiac anomalies, for the assessment of cardiac structure(s) (eg. cardiac chambers and valves, left atrial appendage, interatrial septum, interventricular septum) and function, when performed (list separately in addition to code for echocardiographic imaging Doppler echocardiography, pulsed wave and/or continuous wave with spectral display, complete Doppler echocardiography, pulsed wave and/or continuous wave with spectral display, complete Doppler echocardiography, pulsed wave and/or continuous wave with spectral display, follow-up or limited study Doppler echocardiography, polor flow Prior Authorization goes through eviCore Prior Authorization goes through eviCore			
postprocessing during transesophageal echocardiography or during transthoraci echocardiography for congenital cardiac anomalies, for the assessment of cardiac structure(s) (eg. cardiac chambers and valves, left atrial appendage, interatrial septum, interventricular septum) and function, when performed (List separately in addition to code for echocardiographic imaging Doppler echocardiography, pulsed wave and/or continuous wave with spectral display, complete Doppler echocardiography, pulsed wave and/or continuous wave with spectral display, complete Prior Authorization goes through eviCore			
postprocessing during transesophageal echocardiography or during transthoraci echocardiography for congenital cardiac anomalies, for the assessment of cardiac structure(s) (eg. cardiac chambers and valves, left atrial appendage, interatrial septum, interventricular septum) and function, when performed (List separately in addition to code for echocardiographic imaging Doppler echocardiography, pulsed wave and/or continuous wave with spectral display, complete Doppler echocardiography, pulsed wave and/or continuous wave with spectral display, complete Prior Authorization goes through eviCore	3D echocardiographic imaging and	93319	Prior Authorization goes through eviCore
chocardiography, or during transthoracic echocardiography for congenital cardiac anomalies, for the assessment of cardiac structure(s) (eg. cardiac chambers and valves, left atrial appendage, interatrial septum, interventricular septum) and function, when performed (List separately in addition to code for echocardiographic imaging Doppler echocardiography, pulsed wave and/or continuous wave with spectral display, complete Doppler echocardiography, pulsed wave and/or continuous wave with spectral display, follow-up or limited study Doppler schocardiography color flow 93325 Prior Authorization goes through eviCore			
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assessment of cardiac structure(s) (eg. cardiac chambers and valves, left strial appendage, interatrial septum, interventricular septum) and function, when performed (list separately in addition to code for echocardiographic imaging Doppler echocardiography, pulsed wave and/or continuous wave with spectral display; complete Doppler echocardiography, pulsed wave and/or continuous wave with spectral display; complete Doppler echocardiography, pulsed wave and/or continuous wave with spectral display; follow-up or limited study Doppler echocardiography pulsed wave and/or continuous wave with spectral display; follow-up or limited study Prior Authorization goes through eviCore Prior Authorization goes through eviCore			
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Interventricular septum) and function, when performed (List separately in addition to code for echocardiographic imaging Doppler echocardiography, pulsed wave and/or continuous wave with spectral display; complete Doppler echocardiography, pulsed wave and/or continuous wave with spectral display; complete Doppler echocardiography, pulsed wave and/or continuous wave with spectral display; for an analysis of the continuous wave with spectral display; follow-up or limited study Doppler echocardiography color flow 93325 Prior Authorization goes through eviCore			
when performed (List separately in addition to code for echocardiographic imaging Doppler echocardiography, pulsed wave and/or continuous wave with spectral display, complete Doppler echocardiography, pulsed wave and/or continuous wave with spectral display, complete Doppler echocardiography, pulsed wave and/or continuous wave with spectral display, follow-up or limited study Doppler echocardiography of limited study Prior Authorization goes through eviCore Prior Authorization goes through eviCore			
addition to code for echocardiographic Imaging 93320 Prior Authorization goes through eviCore and/or continuous wave with spectral display; complete Doppler echocardiography, pulsed wave 93321 Prior Authorization goes through eviCore and/or continuous wave with spectral display; follow-up or limited study 93321 Prior Authorization goes through eviCore 93325 Prior Authorization goes through eviCore			
imaging Doppler echocardiography, pulsed wave and/or continuous wave with spectral display; complete Doppler echocardiography, pulsed wave and/or continuous wave with spectral display; complete Doppler echocardiography, pulsed wave and/or continuous wave with spectral display; follow-up or limited study Doppler echocardiography color flow Prior Authorization goes through eviCore Prior Authorization goes through eviCore			
Doppler echocardiography, pulsed wave 93320 Prior Authorization goes through eviCore and/or continuous wave with spectral display; complete Prior Authorization goes through eviCore 93321 Prior Authorization goes through eviCore and/or continuous wave with spectral display; follow-up or limited study Doppler echocardiography color flow 93325 Prior Authorization goes through eviCore			
and/or continuous wave with spectral display; complete Doppler echocardiography, pulsed wave and/or continuous wave with spectral display; follow-up or limited study Doppler schocardiography color flow Prior Authorization goes through eviCore Prior Authorization goes through eviCore Prior Authorization goes through eviCore	magnig		
and/or continuous wave with spectral display; complete Doppler echocardiography, pulsed wave and/or continuous wave with spectral display; follow-up or limited study Doppler schocardiography color flow Prior Authorization goes through eviCore Prior Authorization goes through eviCore Prior Authorization goes through eviCore		93320	Prior Authorization goes through eviCore
display; complete Doppler echocardiography, pulsed wave and/or continuous wave with spectral display; follow-up or limited study Doppler echocardiography color flow 93325 Prior Authorization goes through eviCore	Doppler echocardiography, pulsed wave	i	
Doppler echocardiography, pulsed wave and/or continuous wave with spectral display; follow-up or limited study Doppler echocardiography color flow 93325 Prior Authorization goes through eviCore	and/or continuous wave with spectral		•
and/or continuous wave with spectral display, follow-up or limited study Doppler echocardiography color flow 93325 Prior Authorization goes through eviCore	and/or continuous wave with spectral		
Doppler echocardiography color flow 93325 Prior Authorization goes through eviCore	and/or continuous wave with spectral display; complete Doppler echocardiography, pulsed wave	93321	Prior Authorization goes through eviCore
	and/or continuous wave with spectral display; complete Doppler echocardiography, pulsed wave and/or continuous wave with spectral	93321	Prior Authorization goes through eviCore
lyelocity mapping	and/or continuous wave with spectral display; complete Doppler echocardiography, pulsed wave and/or continuous wave with spectral display; follow-up or limited study		
·	and/or continuous wave with spectral display; complete Doppler echocardiography, pulsed wave and/or continuous wave with spectral display; follow-up or limited study Doppler echocardiography color flow		

Echocardiography, transthoracic, real-		
	93350	Prior Authorization goes through eviCore
time with image documentation (2d),		
with or without m-mode recording,		
during rest and cardiovascular stress test,		
with interpretation and report		
Echocardiography, transthoracic, real-	93351	Prior Authorization goes through eviCore
time with image documentation (2d),		
includes m-mode recording, when		
performed, during rest and cardiovascular		
stress test using treadmill, bicycle exercise		
and/or pharmacologically induced stress,		
with interpretation		
Use of echocardiographic contrast agent	93352	Prior Authorization goes through eviCore
during stress echocardiography (list		
separately in addition to code for primary		
procedure)		
Myocardial strain imaging using speckle	93356	Prior Authorization goes through eviCore
tracking-derived assessment of		,
myocardial mechanics (List separately in		
addition to codes for echocardiography		
imaging)		
Right Heart Catheterization Including	93451	Prior Authorization goes through eviCore
Measurement(S) Of Oxygen Saturation	55431	Filor Authorization goes through evicore
And Cardiac Output, When Performed		
	22452	n to Auto to the control of the total
Left heart catheterization including	93452	Prior Authorization goes through eviCore
intraprocedural injection(s) for left		
ventriculography, imaging supervision		
and interpretation, when performed		
Combined right and left heart	93453	Prior Authorization goes through eviCore
catheterization including intraprocedural		
injection(s) for left ventriculography,		
imaging supervision and interpretation,		
when performed		
Catheter placement in coronary artery(s)	93454	Prior Authorization goes through eviCore
for coronary angiography, including		
intraprocedural injection(s) for coronary		
angiography, imaging supervision and		
interpretation		
Catheter placement in coronary artery(s)	93455	Prior Authorization goes through eviCore
for coronary angiography, including	33433	The ration goestinough evicore
intraprocedural injection(s) for coronary		
angiography, imaging supervision and		
interpretation; with catheter		
placement(s) in bypass graft(s) (internal		
mammary, free arterial venous grafts)		
including intraprocedural injection(s) for		
bypass graft angiography		
Catheter placement in coronary artery(s)	93456	Prior Authorization goes through eviCore
for coronary angiography, including		
intraprocedural injection(s) for coronary		
angiography, imaging supervision and		
interpretation; with right heart		
catheterization		
Catheter placement in coronary artery(s)	93457	Prior Authorization goes through eviCore
for coronary angiography, including		
intraprocedural injection(s) for coronary		
angiography, imaging supervision and		
interpretation; with catheter		
placement(s) in bypass graft(s) (internal		
mammary, free arterial, venous grafts)		
including intraprocedural injection(s) for		
bypass graft angiography and right heart		
catheterization		
Catheter placement in coronary arter-day	03/158	Prior Authorization goes through eviCore
Catheter placement in coronary artery(s)	93458	Prior Authorization goes through eviCore
for coronary angiography, including	93458	Prior Authorization goes through eviCore
for coronary angiography, including intraprocedural injection(s) for coronary	93458	Prior Authorization goes through eviCore
for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and	93458	Prior Authorization goes through eviCore
for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart	93458	Prior Authorization goes through eviCore
for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural	93458	Prior Authorization goes through eviCore
for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography,	93458	Prior Authorization goes through eviCore
for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed		
for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed Catheter placement in coronary artery(s)	93458	Prior Authorization goes through eviCore Prior Authorization goes through eviCore
for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed Catheter placement in coronary artery(s) for coronary angiography, including		
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for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for fet ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft(s)		
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for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for flet ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography	93459	Prior Authorization goes through eviCore
for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography. Catheter placement in coronary artery(s)		
for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography. Catheter placement in coronary artery(s) for coronary angiography, including	93459	Prior Authorization goes through eviCore
for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, including intraprocedural injection(s) for coronary	93459	Prior Authorization goes through eviCore
for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography. Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, inaging supervision and	93459	Prior Authorization goes through eviCore
for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart	93459	Prior Authorization goes through eviCore
for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography. Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization including intraprocedural	93459	Prior Authorization goes through eviCore
for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart	93459	Prior Authorization goes through eviCore

Catheter placement in coronary artery(s)		
	93461	Prior Authorization goes through eviCore
for coronary angiography, including		
intraprocedural injection(s) for coronary		
angiography, imaging supervision and		
interpretation; with right and left heart catheterization including intraprocedural		
injection(s) for left ventriculography,		
when performed, catheter placement(s) in		
bypass graft(s) (internal mammary, free		
arterial, venous grafts) with bypass graft		
angiography		
Left heart catheterization by transseptal	93462	Prior Authorization goes through eviCore
puncture through intact septum or by	33402	Thor Authorization goes through evicore
transapical puncture (list separately in		
addition to code for primary procedure)		
Right heart catheterization for congenital	93593	Prior Authorization goes through eviCore
heart defect(s) including imaging		
guidance by the proceduralist to advance		
the catheter to the target zone; normal		
native connections		
Right heart catheterization for congenital	93594	Prior Authorization goes through eviCore
heart defect(s) including imaging		
guidance by the proceduralist to advance		
the catheter to the target zone; abnormal		
native connections		
Left heart catheterization for congenital	93595	Prior Authorization goes through eviCore
heart defect(s) including imaging		
guidance by the proceduralist to advance		
the catheter to the target zone, normal or abnormal native connections		
	22505	Daine A. Aberirahina annah annah annah annah annah
Right and left heart catheterization for	93596	Prior Authorization goes through eviCore
congenital heart defect(s) including imaging guidance by the proceduralist to		
advance the catheter to the target zone(s);		
normal native connections		
Right and left heart catheterization for	93597	Prior Authorization goes through eviCore
Right and left heart catheterization for congenital heart defect(s) including	2333/	i noi Authorization goes timough evicore
imaging guidance by the proceduralist to		
advance the catheter to the target		
zone(s); connections abnormal native		
connections		
CT Perfusion Brain	0042T	Prior Authorization goes through eviCore
Myocardial sympathetic innervation	0331T	Prior Authorization goes through eviCore
imaging, planar qualitative and	03311	Thornaction goestinough effects
quantitative assessment;		
Myocardial sympathetic innervation	0332T	Prior Authorization goes through eviCore
imaging, planar qualitative and		
quantitative assessment; with		
tomographic SPECT		
Myocardial contrast perfusion	0439T	Prior Authorization goes through eviCore
echocardiography, at rest or with stress,		
for assessment of myocardial ischemia or		
viability (List separately in addition to		
code for primary procedure)		
code for primary procedure) Noninvasive estimated coronary	0501T	Prior Authorization goes through eviCore
code for primary procedure) Noninvasive estimated coronary fractional flow reserve (FFR) derived from	0501T	Prior Authorization goes through eviCore
code for primary procedure) Noninvasive estimated coronary fractional flow reserve (FFR) derived from coronary computed tomography		Prior Authorization goes through eviCore
code for primary procedure) Noninvasive estimated coronary fractional flow reserve (FFR) derived from coronary computed tomography angiography data using computation fluid		Prior Authorization goes through eviCore
code for primary procedure) Noninvasive estimated coronary fractional flow reserve (FFR) derived from coronary computed tomography angiography data using computation fluid dynamics physiologic simulation software		Prior Authorization goes through eviCore
code for primary procedure) Noninvasive estimated coronary fractional flow reserve (FFR) derived from coronary computed tomography angiography data using computation fluid dynamics physiologic simulation software analysis of functional data to assess the		Prior Authorization goes through eviCore
code for primary procedure) Noninvasive estimated coronary fractional flow reserve (FR) derived from coronary computed tomography angiography data using computation fluid dynamics physiologic simulation software analysis of functional data to assess the severity of coronary artery disease; data		Prior Authorization goes through eviCore
code for primary procedure) Noninvasive estimated coronary fractional flow reserve (FFR) derived from coronary computed tomography angiography data using computation fluid dynamics physiologic simulation software analysis of functional data to assess the		Prior Authorization goes through eviCore
code for primary procedure) Noninvasive estimated coronary fractional flow reserve (FR) derived from coronary computed tomography angiography data using computation fluid dynamics physiologic simulation software analysis of functional data to assess the severity of coronary artery disease; data preparation and transmission, analysis of fluid dynamics and simulated maximal coronary hyperemia,		Prior Authorization goes through eviCore
code for primary procedure) Noninvasive estimated coronary fractional flow reserve (FR) derived from coronary computed tomography angiography data using computation fluid dynamics physiologic simulation software analysis of functional data to assess the severity of coronary artery disease; data preparation and transmission, analysis of fluid dynamics and simulated maximal coronary hyperemia, generation of estimated FFR model, with		Prior Authorization goes through eviCore
code for primary procedure) Noninvasive estimated coronary fractional flow reserve (FR) derived from coronary computed tomography angiography data using computation fluid dynamics physiologic simulation software analysis of functional data to assess the severity of coronary artery disease; data preparation and transmission, analysis of fluid dynamics and simulated maximal coronary hyperemia, generation of estimated FFR model, with anatomical data review in comparison		Prior Authorization goes through eviCore
code for primary procedure) Noninvasive estimated coronary fractional flow reserve (FR) derived from coronary computed tomography angiography data using computation fluid dynamics physiologic simulation software analysis of functional data to assess the severity of coronary artery disease; data preparation and transmission, analysis of fluid dynamics and simulated maximal coronary hyperemia, generation of estimated FFR model, with anatomical data review in comparison with estimated FFR model to reconcile		Prior Authorization goes through eviCore
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Removal and replacement of wireless	0519T	Prior Authorization goes through eviCore
cardiac stimulator for left ventricular		
pacing; pulse generator component(s)		
(battery and/or transmitter)		
Removal and replacement of wireless	0520T	Prior Authorization goes through eviCore
cardiac stimulator for left ventricular		
pacing; pulse generator component(s) (battery and/or transmitter), including		
placement of a new electrode		
	05747	Prior Authorization goes through eviCore
Insertion or replacement of implantable cardioverter-defibrillator system with	0571T	Prior Authorization goes through evicore
substernal electrode(s), including all		
imaging guidance and		
electrophysiological evaluation (includes		
defibrillation threshold evaluation,		
induction of arrhythmia, evaluation of		
sensing for arrhythmia termination, and		
programming or reprogramming of		
sensing or therapeutic parameters), when		
performed		
Insertion of substernal implantable	0572T	Prior Authorization goes through eviCore
defibrillator electrode		
Magnetic resonance spectroscopy,	0609T*	Prior Authorization goes through eviCore
determination and		
localization of discogenic pain (cervical,		
thoracic, or lumbar); acquisition of single		
voxel data, per disc, on biomarkers (ie,		
lactic acid, carbohydrate, alanine, laal,		
propionic acid, proteoglycan, and		
collagen) in at least 3 discs		
Magnetic resonance spectroscopy,	0610T*	Prior Authorization goes through eviCore
determination and localization of		
discogenic pain (cervical, thoracic, or		
lumbar); transmission of biomarker data		
for software analysis		
Magnetic resonance spectroscopy,	0611T*	Prior Authorization goes through eviCore
determination and localization of		
discogenic pain (cervical, thoracic, or		
lumbar); postprocessing for algorithmic		
analysis of biomarker data for		
determination of relative chemical		
differences between discs		
Magnetic resonance spectroscopy,	0612T*	Prior Authorization goes through eviCore
determination and localization of		
discogenic pain (cervical, thoracic, or		
lumbar); interpretation and report		
Removal and replacement of substernal	0614T*	Prior Authorization goes through eviCore
implantable		
defibrillator pulse generator		
Automated quantification and	0623T	Prior Authorization goes through eviCore
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		
Automated quantification and	0624T	Prior Authorization goes through eviCore
characterization of coronary		
atherosclerotic plaque to assess severity		
of coronary disease, using data from coronary computed tomographic		
angiography; data preparation and		
transmission		
	DESET	Prior Authorization goes through suifforc
Automated quantification and	0625T	Prior Authorization goes through eviCore
atherosclerotic plaque to assess severity		
of coronary disease, using data from		
coronary computed tomographic		
angiography; computerized analysis of		
data from coronary computed		
tomographic angiography		
Automated quantification and	0626T	Prior Authorization goes through eviCore
characterization of coronary	00201	i noi Authorization goes tinough evicore
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		
Computed tomography, breast, including	0633T*	Prior Authorization goes through eviCore
3D rendering, when performed,		
unilateral; without contrast material		
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Computed tomography, breast, including	0634T*	Prior Authorization goes through eviCore
3D rendering, when performed,		
unilateral; with contrast material(s)		
(-)		
Computed tomography, breast, including	0635T*	Prior Authorization goes through eviCore
3D rendering, when performed,		
unilateral; without contrast, followed by		
contrast material(s)		
Computed tomography, breast, including	0636T*	Prior Authorization goes through eviCore
3D rendering, when performed, bilateral;		· • • • • • • • • • • • • • • • • • • •
without contrast material(s)		
1		

Computed tomography, breast, including 3D rendering, when performed, bilateral; with contrast material(s)	0637T*	Prior Authorization goes through eviCore
Computed tomography, breast, including 3D rendering, when performed, bilateral; without contrast, followed by contrast	0638T*	Prior Authorization goes through eviCore
material(s) Quantitative magnetic resonance for analysis of tissue composition (e.g., fat, iron, water content), including multiparametric data acquisition, data preparation and transmission, interpretation and report, obtained	0648T	Prior Authorization goes through eviCore
without diagnostic MRI examination of the same anatomy (e.g., organ, gland, tissue, target structure) during the same session.	0.00	
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	0649T	Prior Authorization goes through eviCore
without diagnostic MRI examination of the same anatomy (eg, organ, gland, tissue, target structure) during the same session; single organ		
Quantitative magnetic resonance for analysis of tissue composition (eg. fat, Iron, water content), including multiparametric data acquisition, data preparation and 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)	0697T	Prior Authorization goes through eviCore
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); multiple organs (List separately in addition to code for primary procedure)	0698T	Prior Authorization goes through eviCore
Noninvasive arterial plaque analysis using software processing of data from non-coronary computerized tomography angiography; including data preparation and transmission, quantification of the structure and composition of the vessel wall and assessment for lipid-rich necrotic core plaque to assess atherosclerotic plaque stability, data review, interpretation and report		Prior Authorization goes through eviCore
Noninvasive arterial plaque analysis using software processing of data from non-coronary computerized tomography angiography; data preparation and transmission	0711T	Prior Authorization goes through eviCore
Noninvasive arterial plaque analysis using software processing of data from non-coronary computerized tomography angiography; quantification of the structure and composition of the vessel wall and assessment for lipid-rich necrotic core plaque to assess atherosclerotic plaque stability		Prior Authorization goes through eviCore
Noninvasive arterial plaque analysis using software processing of data from non-coronary computerized tomography angiography; data review, interpretation and report	0713T	Prior Authorization goes through eviCore
Transcatheter removal of permanent leadless pacemaker, right ventricular	33275	Prior Authorization goes through eviCore
Computed tomography, thorax, low dose for lung cancer screening, without contrast material(s)		Prior Authorization goes through eviCore
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)	74713	Prior Authorization goes through eviCore
Unlisted Cardiovascular Procedure	78499	Prior Authorization goes through eviCore
MRA Abdomen with contrast	C8900	Prior Authorization goes through eviCore
MRA Abdomen with and w/o contrast	C8901	Prior Authorization goes through eviCore
MRA Abdomen with and w/o contrast MRI Breast w/ contrast unilateral	C8902 C8903	Prior Authorization goes through eviCore
MRI Breast w/ contrast, unilateral MRI Breast w/o contrast, unilateral	C8904	Prior Authorization goes through eviCore Prior Authorization goes through eviCore
MRI Breast w. and w/o contrast, unilateral		Prior Authorization goes through eviCore
MRI Breast Bilateral W/Contrast	C8906	Prior Authorization goes through eviCore
MRI Breast Bilateral W/O Contrast	C8907	Prior Authorization goes through eviCore

MRI Breast Bilateral W/And W/O Contrast	C8908	Prior Authorization goes through eviCore
MRA chest w/contrast (excluding	C8909	Prior Authorization goes through eviCore
myocardium)		
MRA chest w/o contrast (excluding myocardium)	C8910	Prior Authorization goes through eviCore
MRA chest w/ and w/o contrast (excluding	C8911	Prior Authorization goes through eviCore
myocardium)		
MRA lower extremity w/ contrast MRA lower extremity w/o contrast	C8912 C8913	Prior Authorization goes through eviCore Prior Authorization goes through eviCore
MRA lower extremity w/ and w/o contrast	C8914	Prior Authorization goes through eviCore
MRA pelvis w/ contrast MRA pelvis w/o contrast	C8918 C8919	Prior Authorization goes through eviCore Prior Authorization goes through eviCore
MRA pelvis w/ and w/o contrast	C8920	Prior Authorization goes through eviCore
Transthoracic echocardiography	C8921	Prior Authorization goes through eviCore
w/contrast for congenital cardiac anomalies; complete		
Transthoracic echocardiography	C8922	Prior Authorization goes through eviCore
w/contrast for congenital cardiac anomalies; f/u or limited study		
Transthoracic echocardiography	C8923	Prior Authorization goes through eviCore
w/contrast, real-time w/image		
documentation (2d), w/wo m-mode recording; complete		
Transthoracic echocardiography	C8924	Prior Authorization goes through eviCore
w/contrast, real-time w/image		
documentation (2d), w/wo m-mode recording; f/u or limited study		
Transesophageal echocardiography (TEE)	C8925	Prior Authorization goes through eviCore
with contrast, or without contrast		
followed by with contrast, real time with image documentation (2D) (with or		
without M-mode recording); including		
probe placement, image acquisition, interpretation and report		
Transesophageal echocardiography (TEE)	C8926	Prior Authorization goes through eviCore
with contrast, or without contrast		
followed by with contrast, for congenital cardiac anomalies; including probe		
placement, image acquisition,		
interpretation and report		
Transthoracic echocardiography	C8928	Prior Authorization goes through eviCore
w/contrast, real-time w/image documentation (2d), w/wo m-mode		
recording, during rest and cardiovascular		
stress test, w/interpretation and report		
Transthoracic echocardiography with	C8929	Prior Authorization goes through eviCore
contrast, or without contrast followed by		
with contrast, real-time with image documentation (2d), includes m-mode		
recording, when performed, complete,		
with spectral doppler echocardiography,		
and with color flow doppler echocardiography		
Transthoracic echocardiography, with	C8930	Prior Authorization goes through eviCore
contrast, or without contrast followed by		
with contrast, real-time with image documentation (2d), includes m-mode		
recording, when performed, during rest		
and cardiovascular stress test using		
treadmill, bicycle exercise and/or pharmacologically induced stress, with		
interpretation and report; including		
performance of continuous electrocardiographic monitoring, with		
physician supervision		
MRA, W/Dye, Spinal Canal	C8931	Prior Authorization goes through eviCore
MRA, W/O Dye, Spinal Canal	C8932	Prior Authorization goes through eviCore
MRA, W/O & W/ Dye, Spinal Canal MRA, W/ Dye, Upper Extremity	C8933 C8934	Prior Authorization goes through eviCore
MRA, W/O Dye, Upper Extremity MRA, W/O Dye, Upper Extr	C8934 C8935	Prior Authorization goes through eviCore Prior Authorization goes through eviCore
MRA, W/O & W/ Dye, Upper Extr	C8936	Prior Authorization goes through eviCore
Cardiac magnetic resonance imaging for	C9762 *	Prior Authorization goes through eviCore
morphology and function, quantification of segmental dysfunction; with		
strain imaging		
Conding second (1)	C07C2 *	Brita Authoritation and though wife an
Cardiac magnetic resonance imaging for morphology and function, quantification	C9763 *	Prior Authorization goes through eviCore
of segmental dysfunction; with stress		
imaging	50037	Drive Authorization and the second a
Magnetic resonance cholangiopancreato- graphy (MRCP)	\$8037	Prior Authorization goes through eviCore
Magnetic Resonance Imaging (MRI), Low-	58042	Prior Authorization goes through eviCore
Field Electron Beam Computed Tomography	58092	Prior Authorization goes through eviCore
(Also Known As Ultrafast CT, CINET)	30032	i noi Admonzation goes timough exicore
MSK (Musculoskeletal)	Codes	Prior Authorization Requirement
Arthroscopy, hip, surgical; with labral repair Arthroscopy, hip, surgical; with	29916 29915	Prior Authorization goes through eviCore
acetabuloplasty (i.e., treatment of pincer	20010	Prior Authorization goes through eviCore
lesion) Arthroscopy, hip, surgical; with femoroplasty	29914	Prior Authorization goes through eviCore
(i.e., treatment of cam lesion)	29863	
Arthroscopy, hip, surgical; with synovectomy		Prior Authorization goes through eviCore
Arthroscopy, hip, surgical; with debridement/shaving of articular cartilage	29862	Prior Authorization goes through eviCore
(chondroplasty), abrasion arthroplasty, and/or		
resection of labrum Arthroscopy, hip, surgical; with removal of	29861	Prior Authorization goes through eviCore
loose body or foreign body		

Arthroscopy, hip, diagnostic with or without synovial biopsy (separate procedure)	29860	Prior Authorization goes through eviCore
Revision of total hip arthroplasty; femoral	27138	Prior Authorization goes through eviCore
component only, with or without allograft Revision of total hip arthroplasty; acetabular	27137	Prior Authorization goes through eviCore
component only, with or without autograft or allograft		, , ,
Revision of total hip arthroplasty; both	27134	Prior Authorization goes through eviCore
components, with or without autograft or allograft		
Conversion of previous hip surgery to total hip arthroplasty, with or without autograft or	27132	Prior Authorization goes through eviCore
allograft		
Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip	27130	Prior Authorization goes through eviCore
arthroplasty), with or without autograft or		
allograft Hemiarthroplasty, hip, partial (e.g., femoral	27125	Prior Authorization goes through eviCore
stem prosthesis, bipolar arthroplasty) Arthroscopically aided posterior cruciate	29889	Prior Authorization goes through eviCore
ligament repair/augmentation or		The Authorization goes through evicore
reconstruction Arthroscopically aided anterior cruciate	29888	Prior Authorization goes through eviCore
ligament repair/augmentation or reconstruction		
Arthroscopy, knee, surgical; drilling for intact	29887	Prior Authorization goes through eviCore
osteochondritis dissecans lesion with internal fixation		
Arthroscopy, knee, surgical; drilling for intact osteochondritis dissecans lesion	29886	Prior Authorization goes through eviCore
Arthroscopy, knee, surgical; drilling for	29885	Prior Authorization goes through eviCore
osteochondritis dissecans with bone grafting, with or without internal fixation (including		
debridement of base of lesion)	anno.	Brown to the Company of the Company
Arthroscopy, knee, surgical; with lysis of adhesions, with or without manipulation	29884	Prior Authorization goes through eviCore
(separate procedure) Arthroscopy, knee, surgical; with meniscus	29883	Prior Authorization goes through eviCore
repair (medial AND lateral)		
Arthroscopy, knee, surgical; with meniscus repair (medial OR lateral)	29882	Prior Authorization goes through eviCore
Arthroscopy, knee, surgical; with meniscectomy (medial OR lateral, including	29881	Prior Authorization goes through eviCore
any meniscal shaving) including		
debridement/shaving of articular cartilage (chondroplasty), same or separate		
compartment(s), when performed		
Arthroscopy, knee, surgical; with meniscectomy (medial AND lateral, including	29880	Prior Authorization goes through eviCore
any meniscal shaving) including debridement/shaving of articular cartilage		
(chondroplasty), same or separate		
compartment(s), when performed Arthroscopy, knee, surgical; abrasion	29879	Prior Authorization goes through eviCore
arthroplasty (includes chondroplasty where		
necessary) or multiple drilling or microfracture		
Arthroscopy, knee, surgical; debridement/shaving of articular cartilage	29877	Prior Authorization goes through eviCore
(chondroplasty)		
Arthroscopy, knee, surgical; synovectomy, major, 2 or more compartments (e.g., medial	29876	Prior Authorization goes through eviCore
or lateral) Arthroscopy, knee, surgical; synovectomy,	29875	Prior Authorization goes through eviCore
limited (e.g., plica or shelf resection)	25070	The Authorization goes through evicore
(separate procedure) Arthroscopy, knee, surgical; for removal of	29874	Prior Authorization goes through eviCore
loose body or foreign body (e.g., osteochondritis dissecans fragmentation,		, , ,
chondral fragmentation)		
Arthroscopy, knee, surgical; with lateral release	29873	Prior Authorization goes through eviCore
Arthroscopy, knee, surgical; for infection, lavage and drainage	29871	Prior Authorization goes through eviCore
Arthroscopy, knee, diagnostic, with or without	29870	Prior Authorization goes through eviCore
synovial biopsy (separate procedure)		
Arthroscopy, knee, surgical; meniscal	29868	Prior Authorization goes through eviCore
transplantation (includes arthrotomy for meniscal insertion), medial or lateral		
Arthroscopy, knee, surgical; osteochondral allograft (e.g., mosaicplasty)	29867	Prior Authorization goes through eviCore
Arthroscopy, knee, surgical; osteochondral	29866	Prior Authorization goes through eviCore
autograft(s) (e.g., mosaicplasty) (includes harvesting of the autograft[s])		
Arthroscopy, shoulder, surgical; repair of SLAP lesion	29807	Prior Authorization goes through eviCore
Arthroscopy, shoulder, surgical;	29806	Prior Authorization goes through eviCore
capsulorrhaphy Arthroscopy, shoulder, diagnostic, with or	29805	Prior Authorization goes through eviCore
without synovial biopsy (separate procedure)		
Revision of total knee arthroplasty, with or	27487	Prior Authorization goes through eviCore
without allograft; femoral and entire tibial component		
Revision of total knee arthroplasty, with or	27486	Prior Authorization goes through eviCore
without allograft; 1 component Arthroplasty, knee, condyle and plateau;	27447	Prior Authorization goes through eviCore
medial AND lateral compartments with or without patella resurfacing (total knee		
arthroplasty)		
Arthroplasty, knee, condyle and plateau; medial OR lateral compartment	27446	Prior Authorization goes through eviCore
Arthroplasty, femoral condyles or tibial plateau(s), knee; with debridement and partial	27443	Prior Authorization goes through eviCore
synovectomy		
Arthroplasty, femoral condyles or tibial plateau(s), knee;	27442	Prior Authorization goes through eviCore
Arthroplasty, knee, tibial plateau; with	27441	Prior Authorization goes through eviCore
debridement and partial synovectomy Arthroplasty, knee, tibial plateau;	27440	Prior Authorization goes through eviCore
Arthroplasty, patella; with prosthesis	27438	Prior Authorization goes through eviCore
Quadricepsplasty (e.g., Bennett or Thompson type)	27430	Prior Authorization goes through eviCore
Ligamentous reconstruction (augmentation),	27429	Prior Authorization goes through eviCore
knee; intra-articular (open) and extra-articular		
Ligamentous reconstruction (augmentation), knee; intra-articular (open)	27428	Prior Authorization goes through eviCore
Ligamentous reconstruction (augmentation),	27427	Prior Authorization goes through eviCore
knee; extra- articular Lateral retinacular release, open	27425	Prior Authorization goes through eviCore
Reconstruction of dislocating patella; with	27424	Prior Authorization goes through eviCore
patellectomy		1

Reconstruction of dislocating patella; with	ож (оо	
extensor realignment and/or muscle	27422	Prior Authorization goes through eviCore
advancement or release (e.g., Campbell, Goldwaite type procedure)		
Reconstruction of dislocating patella; (e.g.,	27420	Prior Authorization goes through eviCore
Hauser type procedure) Anterior tibial tubercleplasty (e.g., Maquet	27418	Prior Authorization good through ouiCoro
type procedure)		Prior Authorization goes through eviCore
Osteochondral autograft(s), knee, open (e.g., mosaicplasty) (includes harvesting of	27416	Prior Authorization goes through eviCore
autograft[s])		
Osteochondral allograft, knee, open Autologous chondrocyte implantation, knee	27415 27412	Prior Authorization goes through eviCore Prior Authorization goes through eviCore
Arthrotomy with meniscus repair, knee	27403	Prior Authorization goes through evicore Prior Authorization goes through eviCore
Arthrotomy, with synovectomy, knee; anterior	27335	Prior Authorization goes through eviCore
AND posterior including popliteal area		
Arthrotomy, with synovectomy, knee; anterior	27334	Prior Authorization goes through eviCore
OR posterior Arthrotomy, with excision of semilunar	27333	Prior Authorization goes through eviCore
cartilage (meniscectomy) knee; medial AND lateral		
Arthrotomy, with excision of semilunar	27332	Prior Authorization goes through eviCore
cartilage (meniscectomy) knee; medial OR lateral		
Arthroscopy, shoulder, surgical; biceps	29828	Prior Authorization goes through eviCore
tenodesis Arthroscopy, shoulder, surgical; with rotator	29827	Prior Authorization goes through eviCore
cuff repair		
Arthroscopy, shoulder, surgical; decompression of subacromial space with	29826	Prior Authorization goes through eviCore
partial acromioplasty, with coracoacromial		
ligament (i.e., arch) release, when performed (List separately in addition to code for		
primary procedure)	29825	Dries Authorization goes through suif are
Arthroscopy, shoulder, surgical; with lysis and resection of adhesions, with or without	20025	Prior Authorization goes through eviCore
manipulation Arthroscopy, shoulder, surgical; distal	29824	Prior Authorization goes through eviCore
claviculectomy including distal articular	2002-	i noi Authorization gues tillough evicore
surface (Mumford procedure) Arthroscopy, shoulder, surgical; debridement,	29823	Prior Authorization goes through eviCore
extensive, 3 or more discrete structures (eg,	20020	Filor Authorization goes through evicore
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])		
Arthroscopy, shoulder, surgical; debridement,	29822	Prior Authorization goes through eviCore
limited, 1 or 2 discrete structures (eg,		The Nation Lation goes through effective
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])		
Arthroscopy, shoulder, surgical;	29821	Prior Authorization goes through eviCore
synovectomy, complete	29820	
Arthroscopy, shoulder, surgical; synovectomy, partial	29620	Prior Authorization goes through eviCore
Arthroscopy, shoulder, surgical; with removal	29819	Prior Authorization goes through eviCore
of loose body or foreign body Revision of total shoulder arthroplasty,	23474	Prior Authorization goes through eviCore
including allograft when performed; humeral		
and glenoid component Revision of total shoulder arthroplasty,	23473	Prior Authorization goes through eviCore
Revision of total shoulder arthroplasty, including allograft when performed; humeral or	23473	Prior Authorization goes through eviCore
Revision of total shoulder arthroplasty, including allograft when performed; humeral or glenoid component Arthroplasty, glenohumeral joint; total	23472 23472	Prior Authorization goes through eviCore Prior Authorization goes through eviCore
Revision of total shoulder arthroplasty, including allograft when performed; humeral or glenoid component Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral		
Revision of total shoulder arthroplasty, including allograft when performed; humeral or glenoid component Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (e.g., total shoulder)) Arthroplasty, glenohumeral joint;		
Revision of total shoulder arthroplasty, including allograft when performed; humeral or glenoid component Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (e.g., total shoulder))	23472	Prior Authorization goes through eviCore
Revision of total shoulder arthroplasty, including allogard when performed; humeral or glenoid component Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (e.g., total shoulder)) Arthroplasty, glenohumeral joint; hemiarthroplasty, glenohumeral joint; hemiarthroplasty, glenohumeral joint, any type multi-directional instability	23472 23470 23466	Prior Authorization goes through eviCore Prior Authorization goes through eviCore Prior Authorization goes through eviCore
Revision of total shoulder arthroplasty, including allogard when performed; humeral or glenoid component Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (e.g., total shoulder)) Arthroplasty, glenohumeral joint; hemiarthroplasty, glenohumeral joint; hemiarthroplasty Capsulornaphy, glenohumeral joint, any type multi-directional instability Capsulornaphy, glenohumeral joint, posterior, with or without bone block	23472 23470 23466 23465	Prior Authorization goes through eviCore
Revision of total shoulder arthroplasty, including allogard when performed; humeral or glenoid component. Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (e.g., total shoulder)). Arthroplasty, glenohumeral joint, berriarthroplasty. Capsulorrhapsty. Capsulorrhapsty. Capsulorrhapsty. Glenohumeral joint, posterior, with or without bone block. Capsulorrhapsty, glenohumeral joint, posterior, with or without bone block. Capsulorrhapsty, antenior, any type; with	23472 23470 23466	Prior Authorization goes through eviCore Prior Authorization goes through eviCore Prior Authorization goes through eviCore
Revision of total shoulder arthroplasty, including allogard when performed; humeral or glenoid component. Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral epslacement (e.g., total shoulder)). Arthroplasty, glenohumeral joint; hemiarthroplasty. Genohumeral joint, any type multi-directional instability. Capsulorrhaphy, glenohumeral joint, posterior, with or without bone block. Capsulorrhaphy, antenior, any type; with coracoid process transfer.	23472 23470 23466 23465	Prior Authorization goes through eviCore
Revision of total shoulder arthroplasty, including allogard when performed; humeral or glenoid component Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (e.g., total shoulder)) Arthroplasty, glenohumeral joint; hemi-arthroplasty, glenohumeral joint, any type multi-directional instability Capsulorrhaphy, glenohumeral joint, posterior, with or without bone block Capsulorrhaphy, anterior, any type; with corracoid process transfer Capsulorrhaphy, anterior, any type; with bone block block	23472 23470 23466 23465 23462	Prior Authorization goes through eviCore
Revision of total shoulder arthroplasty, including allogard when performed; humeral or glenoid component Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (e.g., total shoulder)) Arthroplasty, glenohumeral joint; hemi-arthroplasty, glenohumeral joint, any type multi-directional instability Capsulorrhaphy, glenohumeral joint, posterior, with or without bone block Capsulorrhaphy, anterior, any type; with corracoid process transfer Capsulorrhaphy, anterior, any type; with bone block Capsulorrhaphy, anterior, any type; with bone block Capsulorrhaphy, anterior, any type; with bone block Capsulorrhaphy, anterior; with labral repair (e.g., Bankart procedure)	23472 23470 23466 23465 23462 23462 23460 23455	Prior Authorization goes through eviCore
Revision of total shoulder arthroplasty, including allogard when performed; humeral or glenoid component. Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral reglacement (e.g., total shoulder)). Arthroplasty, glenohumeral joint; humrarthroplasty. Genohumeral joint, any type multi-directional instability. Capsulorrhaphy, glenohumeral joint, posterior, with or without bone block. Capsulorrhaphy, alterior, any type; with coracoid process transfer. Capsulorrhaphy, anterior, any type; with bone block. Capsulorrhaphy, anterior, with labral repair (e.g., Bankart procedure).	23472 23470 23466 23465 23462 23460	Prior Authorization goes through eviCore
Revision of total shoulder arthroplasty, including allogard when performed; humeral or glenoid component. Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (e.g., total shoulder)) Arthroplasty, glenohumeral joint, themiarthroplasty. Capsulormapphy, glenohumeral joint, any type multi-directional instability. Capsulormapphy, glenohumeral joint, posterior, with or without bone block. Capsulormaphy, alterior, any type; with corracold process transfer Capsulormaphy, anterior, any type; with bone block. Capsulormaphy, anterior, any type; with bone block. Capsulormaphy, anterior, any type; with bone block. Capsulormaphy, anterior; with labrai repair (e.g., Bankart procedure). Resection or transplantation of long tendon of long tendon of	23472 23470 23466 23465 23462 23462 23460 23455	Prior Authorization goes through eviCore
Revision of total shoulder arthroplasty, including allogard when performed; humeral or glenoid component Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (e.g., total shoulder)) Arthroplasty, glenohumeral joint; hemiarthroplasty, glenohumeral joint, any type multi-directional instability Capsulorrhaphy, glenohumeral joint, posterior, with or without bone block Capsulorrhaphy, anterior, any type; with corracoid process transfer Capsulorrhaphy, anterior, any type; with bone block Capsulorrhaphy, anterior, my type; with bone block Capsulorrhaphy, anterior, with labral repair (e.g., Bankard procedure) Capsulorrhaphy, anterior, ritti-platt procedure or Magnuson type operation	23472 23470 23466 23465 23462 23460 23455 23450	Prior Authorization goes through eviCore
Revision of total shoulder arthroplasty, including allogard when performed; humeral or glenoid component Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral neglacement (e.g., total shoulder)). Arthroplasty, glenohumeral joint; hemiarthroplasty, glenohumeral joint, any type multi-directional instability. Capsulorhaphy, glenohumeral joint, posterior, with or without bone block. Capsulorhaphy, anterior, any type; with corracoid process transfer capsulorhaphy, anterior, with labral repair (e.g., Bankart procedure). Capsulorhaphy, anterior; puttl-Platt procedure of the pr	23472 23470 23466 23465 23462 23462 23460 23455 23450 23440	Prior Authorization goes through eviCore
Revision of total shoulder arthroplasty, including allogarth when performed; humeral or glenoid component Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (e.g., total shoulder)) Arthroplasty, glenohumeral joint; hemiarthroplasty, glenohumeral joint, any type multi-directional instability Capsulorrhaphy, glenohumeral joint, posterior, with or without bone block Capsulorrhaphy, anterior, any type; with corracoid process transfer Capsulorrhaphy, anterior, any type; with bone block Capsulorrhaphy, anterior, with labral repair (e.g., Bankart procedure) Resection or transplantation of the procedure or Magnuson type operation Resection or transplantation of the procedure or Magnuson type operation Reconstruction of complete shoulder (rotator) cuff avulsion, chronic (includer, chronic (includer)	23472 23470 23466 23465 23462 23462 23460 23455 23450 23440	Prior Authorization goes through eviCore
Revision of total shoulder arthroplasty, including allogarth when performed; humeral or glenoid component Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral neglacement (e.g., total shoulder)) Arthroplasty, glenohumeral joint; hemiralthroplasty Capsulorrhaphy, glenohumeral joint, any type multi-directional instability Capsulorrhaphy, glenohumeral joint, posterior, with or without bone block Capsulorrhaphy, arterior, any type; with corracod process transfer Capsulorrhaphy, arterior, any type; with bone block Capsulorrhaphy, anterior, only type; with bone block Capsulorrhaphy, anterior	23472 23470 23466 23465 23462 23462 23460 23455 23450 23440	Prior Authorization goes through eviCore
Revision of total shoulder arthroplasty, including allogarth when performed; humeral or glenoid component Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral neglacement (e.g., total shoulder)) Arthroplasty, glenohumeral joint; hemisarthroplasty (e.g., total shoulder) Arthroplasty, glenohumeral joint, any type multi-directional instability Capsulorrhaphy, glenohumeral joint, posterior, with or without bone block Capsulorrhaphy, arterior, any type; with corracod process transfer Capsulorrhaphy, arterior, any type; with bone block Capsulorrhaphy, anterior, only type; with procedure of Magnuson type operation Flessection or transplantation of long tendon of bicops Reconstruction of complete shoulder (rotator) cuff avulsion, chronic (includes acronisplasty) Coracoacromal ligament release, with or without acromisplasty or without a	23472 23470 23466 23465 23462 23460 23450 23450 23450 23440 23430 23420	Prior Authorization goes through eviCore
Revision of total shoulder arthroplasty, including allogarth when performed; humeral or glenoid component Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral neglacement (e.g., total shoulder)) Arthroplasty, glenohumeral joint, beneriarthroplasty (glenohumeral joint, any type multi-directional instability Capsulorhaphy, glenohumeral joint, posterior, with or without bone block Capsulorhaphy, anterior, any type; with corracoid process transfer Capsulorhaphy, anterior, with labral repair (e.g., Bankart procedure) (e.g., Bankart procedure) Resection or transplantation of long tendon of biceps Reconstruction of complete shoulder (ordinal procedure or the shoulder (includes acromioplasty) Coracoacoromal ligament release, with or without acromioplasty (e.g., c.g., chronic)	23472 23470 23466 23465 23462 23462 23460 23455 23450 23440 23440 23420 23415 23412	Prior Authorization goes through eviCore
Revision of total shoulder arthroplasty, including allogarth when performed; humeral or glenoid component Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral neglacement (e.g., total shoulder)) Arthroplasty, glenohumeral joint, beneriarthroplasty (glenohumeral joint, any type multi-directional instability Capsulorhaphy, glenohumeral joint, posterior, with or without bone block Capsulorhaphy, antenior, any type; with corracoid process transfer Capsulorhaphy, antenior, any type; with bone block Capsulorhaphy, antenior, with labral repair (e.g., Bankart procedure) for the procedure or the superior procedure of	23472 23470 23466 23465 23462 23460 23450 23450 23450 23440 23440 23430 23420 23415 23412 23410	Prior Authorization goes through eviCore
Revision of total shoulder arthroplasty, including allogard when performed; humeral or glenoid component Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (e.g., total shoulder)) Arthroplasty, glenohumeral joint; hemiarthroplasty, glenohumeral joint, any type multi-directional instability Capsulorrhaphy, glenohumeral joint, posterior, with or without bone block. Capsulorrhaphy, anterior, any type; with corracoid process transfer Capsulorrhaphy, anterior, any type; with bone block. Capsulorrhaphy, anterior, with labral repair (e.g., Bankart procedure) Tenseucino or transplantation of the procedure or Magnuson type operation Resection or transplantation of the procedure of the proced	23472 23470 23466 23465 23462 23462 23460 23455 23450 23440 23440 23420 23415 23412	Prior Authorization goes through eviCore
Revision of total shoulder arthroplasty, including allogarth when performed; humeral or glenoid component Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (e.g., total shoulder)) Arthroplasty, glenohumeral joint, any type replacement (e.g., total shoulder) Arthroplasty, glenohumeral joint, any type runti-directional instability Capsulorrhaphy, glenohumeral joint, posterior, with or without bone block Capsulorrhaphy, anterior, any type; with corraciod process transfer Capsulorrhaphy, anterior, any type; with bone block Resolution transplantation or long tendon of bicops Tendosis of long tendon of bicops Reconstruction of complete shoulder (rotator) ctiff avulsion, chronic (includes acromisplasty) Coracoacromial ligament release, with or without acromisplasty or caronisonectomy, partial, with or without coracoacromial ligament release	23472 23470 23466 23465 23462 23460 23455 23450 23440 23430 23420 23415 23410 23130	Prior Authorization goes through eviCore
Revision of total shoulder arthroplasty, including allogard when performed; humeral or glenoid component Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral neglacement (e.g., total shoulder)). Arthroplasty, glenohumeral joint, hemiarthroplasty, glenohumeral joint, hemiarthroplasty, glenohumeral joint, any type multi-directional instability. Capsulorhaphy, glenohumeral joint, posterior, with or without bone block. Capsulorhaphy, anterior, any type; with corracoid process transfer capsulorhaphy, anterior, with labral repair (e.g., Bankart procedure or hemioris, posterior, with control to the procedure of the procedure	23472 23470 23466 23466 23465 23462 23460 23450 23450 23440 23430 23440 23440 23430 23440 23430 23415 23417 23410 23130	Prior Authorization goes through eviCore
Revision of total shoulder arthroplasty, including allogarth when performed; humeral or glenoid component Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral neglacement (e.g., total shoulder)) Arthroplasty, glenohumeral joint, beneriarthroplasty (glenohumeral joint, any type multi-directional instability Capsulorhaphy, glenohumeral joint, posterior, with or without bone block Capsulorhaphy, anterior, any type; with corracoid process transfer Capsulorhaphy, anterior, any type; with bone block Capsulorhaphy, anterior, with labral repair (e.g., Bankart procedure of hagnuson type operation Resection or transplantation of long tendon of biceps Reconstruction of complete shoulder (rotator) curf avulsion, chronic (includes acronicipalsty) Coracoacromial ligament release, with or without acromoplasty curf of ruptured musculotendinous curf (e.g., rotator curf) open; chronic Repair of ruptured musculotendinous curf (e.g., rotator curf) open; courfl open; acut partial, with or without acromoplasty or acromionectomy, partial (e.g., rotator curf) open; courfl open; acut partial, with or without coracoacromial ligament release (e.g., Sever type procedure).	23472 23470 23466 23465 23462 23460 23455 23450 23440 23430 23420 23415 23410 23130	Prior Authorization goes through eviCore
Revision of total shoulder arthroplasty, including allogarth when performed; humeral or glenoid component Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (e.g., total shoulder)) Arthroplasty, glenohumeral joint, any type multi-directional instability Capsulorrhaphy, glenohumeral joint, any type multi-directional instability Capsulorrhaphy, glenohumeral joint, any type multi-directional instability Capsulorrhaphy, glenohumeral joint, posterior, with or without bene block Capsulorrhaphy, anterior, any type; with corracoid process transfer Capsulorrhaphy, anterior, any type; with bone block Capsulorrhaphy, anterior; multi-directional corracoid process transfer Capsulorrhaphy, anterior; with labral repair (e.g., and and proceedure or Magnuson type operation Resection or transplantation of long tendon of biceps Tenodesis of long tendon of bi	23472 23470 23466 23466 23465 23462 23460 23450 23450 23440 23430 23440 23440 23430 23440 23430 23415 23417 23410 23130	Prior Authorization goes through eviCore
Revision of total shoulder arthroplasty, including allogarth when performed; humeral or glenoid component Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral neglacement (e.g., total shoulder)) Arthroplasty, glenohumeral joint, beneriarthroplasty (glenohumeral joint, any type multi-directional instability Capsulorhaphy, glenohumeral joint, posterior, with or without bone block Capsulorhaphy, anterior, any type; with corracoid process transfer Capsulorhaphy, anterior, any type; with bone block Capsulorhaphy, anterior, with labral repair (e.g., Bankart procedure of hagnuson type operation Resection or transplantation of long tendon of biceps Reconstruction of complete shoulder (rotator) curf avulsion, chronic (includes acronicipalsty) Coracoacromial ligament release, with or without acromoplasty curf of ruptured musculotendinous curf (e.g., rotator curf) open; chronic Repair of ruptured musculotendinous curf (e.g., rotator curf) open; courfl open; acut partial, with or without acromoplasty or acromionectomy, partial (e.g., rotator curf) open; courfl open; acut partial, with or without coracoacromial ligament release (e.g., Sever type procedure).	23472 23470 23466 23465 23462 23460 23450 23450 23440 23420 23440 23420 23415 23410 23130 23120 23020	Prior Authorization goes through eviCore
Revision of total shoulder arthroplasty, including allogard when performed; humeral or glenoid component Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral neglacement (e.g., total shoulder)) Arthroplasty, glenohumeral joint; hemi-arthroplasty, glenohumeral joint, any type multi-directional instability Capsulorhaphy, glenohumeral joint, posterior, with or without bone block Capsulorhaphy, anterior, any type; with corracoid process transfer capsulorhaphy, anterior, any type; with corracoid process transfer capsulorhaphy, anterior, with labral repair (e.g., Bankart procedure of hemionic procedure of hard proc	23472 23470 23466 23465 23462 23460 23450 23450 23450 23440 23430 23420 23415 23410 23130 23120 23200 23000	Prior Authorization goes through eviCore
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Revision of total shoulder arthroplasty, including allogarth when performed; humeral or glenoid component Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (e.g., total shoulder)) Arthroplasty, glenohumeral joint, any type multi-directional stability Capsulorrhaphy, glenohumeral joint, any type multi-directional instability Capsulorrhaphy, glenohumeral joint, posterior, with or without bene block Capsulorrhaphy, anterior, any type; with corracoid process transfer Capsulorrhaphy, anterior, any type; with corracoid process transfer Capsulorrhaphy, anterior, any type; with bone block Capsulorrhaphy, anterior, any type; with corracoid process transfer Capsulorrhaphy, anterior, any type; with bone block (e.g., Bankart procedure) Capsulorrhaphy, anterior, any type; with procedure or Magnuson type operation Resection or transplantation of long tendon of blocps Tenodesis of long tendon of blocps Tenoderial procedure of complete shoulder (rotator) coff avulsion, chronic (includes acromisplasty) Corracoacromial igament release, with or without acromisplasty or acromisonetcomy, partial, with or without coracoacromial ligament release Caviculectomy; partial Capsular contracture release (e.g., Sever type procedure) Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level	23472 23470 23466 23465 23462 23460 23455 23450 23440 23430 23420 23415 23412 23410 23130 23120 23020 22869	Prior Authorization goes through eviCore
Revision of total shoulder arthroplasty, including allogarth when performed; humeral or glenoid component Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (e.g., total shoulder)) Arthroplasty, glenohumeral joint, any type multi-directional instability Capsulorrhaphy, glenohumeral joint, any type multi-directional instability Capsulorrhaphy, glenohumeral joint, posterior, with or without bone block Capsulorrhaphy, anterior, any type; with corraciol process transfer Capsulorrhaphy, anterior, any type; with corraciol process transfer Capsulorrhaphy, anterior, any type; with bone block Capsulorrhaphy, anterior, any type; with corraciod corracion of the proceedure or Magnuson type operation Resection or transplantation of long tenden of biceps Tenodesis of long tenden of biceps Tenoderial proceedure of complete shoulder (rotator) coff avulsion, chronic (includes acromisplasty) Corracoacromial igament release, with or without acromisplasty or acromisonetcomy, partial, with or without coracoacromial ligament release Caviculectomy; partial Capsular contracture release (e.g., Sever type proceedure) Insertion of interfaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single jeven	23472 23470 23466 23465 23462 23460 23450 23450 23450 23440 23430 23420 23415 23410 23130 23120 23200 23000	Prior Authorization goes through eviCore
Revision of total shoulder arthroplasty, including allogard when performed; humeral or glenoid component Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral neglacement (e.g., total shoulder)) Arthroplasty, glenohumeral joint; hemi-arthroplasty, glenohumeral joint, any type multi-directional instability Capsulorhaphy, glenohumeral joint, posterior, with or without bone block Capsulorhaphy, antenior, any type; with correction or some process transfer capsulorhaphy, antenior, any type; with bone block Capsulorhaphy, antenior, with labral repair (e.g., Bankart procedure) Capsulorhaphy, antenior, with labral repair (e.g., Bankart procedure) Capsulorhaphy, antenior, puttl-Platt procedure of kapsulorhaphy, antenior, puttl-Platt puttler of kapsulorhaphy, antenior, puttl-Platt puttler of kapsulorhaphy, antenior, puttler	23472 23470 23466 23465 23462 23460 23455 23450 23440 23430 23420 23415 23412 23410 23130 23120 23020 22869	Prior Authorization goes through eviCore
Revision of total shoulder arthroplasty, including allogarth when performed; humeral or glenoid component Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral neglacement (e.g., total shoulder)) Arthroplasty, glenohumeral joint, between the placement (e.g., total shoulder). Arthroplasty, glenohumeral joint, any type multi-directional instability Capsulorrhaphy, glenohumeral joint, posterior, with or without bone block Capsulorrhaphy, anterior, any type; with corracoid process transfer Capsulorrhaphy, anterior, any type; with bone block Capsulorrhaphy, anterior, with labral repair (e.g., Bankart procedure of headings). The procedure of headings are procedured to the procedure of headings and headi	23472 23470 23466 23465 23462 23460 23455 23450 23440 23430 23420 23415 23412 23410 23130 23120 23020 22869	Prior Authorization goes through eviCore
Revision of total shoulder arthroplasty, including allogarth when performed; humeral or glenoid component Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (e.g., total shoulder)) Arthroplasty, glenohumeral joint, any type multi-directional instability Capsulorrhaphy, glenohumeral joint, any type multi-directional instability Capsulorrhaphy, glenohumeral joint, posterior, with or without bone block Capsulorrhaphy, anterior, any type; with corraciod process transfer Capsulorrhaphy, anterior, any type; with corraciod process transfer Capsulorrhaphy, anterior, any type; with bone block Capsulorrhaphy, anterior, any type; with corraciod process transfer Capsulorrhaphy, anterior, any type; with some block Capsulorrhaphy, anterior, any type; with corraciod corracioder or Adaptive Departion Resection or transplantation of long tenden of biceps Tenodesis of long te	23472 23470 23466 23465 23462 23460 23455 23450 23440 23420 23420 23415 23410 23130 23120 23120 23020 22869	Prior Authorization goes through eviCore
Revision of total shoulder arthroplasty, including allogarth when performed; humeral or glenoid component Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (e.g., total shoulder)) Arthroplasty, glenohumeral joint, any type multi-directional instability Capsulorrhaphy, glenohumeral joint, any type multi-directional instability Capsulorrhaphy, glenohumeral joint, posterior, with or without bone block Capsulorrhaphy, anterior, any type; with corraciol process transfer Capsulorrhaphy, anterior, any type; with corraciol process transfer Capsulorrhaphy, anterior, any type; with bone block Capsulorrhaphy, anterior, any type; with corraciod proceedure or Magnuson type operation Resection or transplantation of long tenden of biceps Tenodesis of long tenden of biceps Reconstruction of complete shoulder (rotator) cuff avulsion, chronic (includes acromiciplasty) Corracoacromial igament release, with or without acromiciplasty or acrominentionus cuff (e.g., rotator cuff) open, chronic Repair of ruptured musculotendinous cuff (e.g., rotator cuff) open, chronic Repair of ruptured musculotendinous cuff (e.g., rotator cuff) open, chronic Repair of ruptured musculotendinous cuff (e.g., rotator cuff) open, chronic Repair of ruptured musculotendinous cuff (e.g., rotator cuff) open, chronic Repair of ruptured musculotendinous cuff (e.g., rotator cuff) open, chronic Repair of ruptured musculotendinous cuff (e.g., rotator cuff) open, chronic Repair of ruptured musculotendinous cuff (e.g., rotator cuff) open, chronic Repair of ruptured musculotendinous cuff (e.g., rotator cuff) open, chronic Repair of ruptured musculotendinous cuff (e.g., rotator cuff) open, chronic Repair of ruptured musculotendinous cuff (e.g., rotator cuff) open, chronic Repair of ruptured musculotendinous cuff (e.g., rot	23472 23470 23466 23465 23462 23460 23455 23450 23440 23430 23420 23415 23412 23410 23130 23120 23020 22869	Prior Authorization goes through eviCore
Revision of total shoulder arthroplasty, including allograft when performed; humeral or glenoid component Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral neplacement (e.g., total shoulder)) Arthroplasty, glenohumeral joint; hemiarthroplasty, glenohumeral joint, any type multi-directional instability Capsulorrhaphy, glenohumeral joint, posterior, with or without bone block Capsulorrhaphy, antenior, any type; with coraciod process transfer Capsulorrhaphy, antenior, any type; with bone block Capsulorrhaphy, antenior, with labral repair (e.g., Bankart procedure of wagnuson type operation Resection or transplantation of long tendon of biceps Tenodesis of long tendon of long tendon of biceps Tenodesis of long tendon of biceps Tenodesis of long tendon of biceps Tenodesis of long tendon of long tendon of biceps Tenodesis of long tendon of lo	23472 23470 23466 23465 23462 23460 23455 23450 23440 23420 23420 23415 23410 23130 23120 23120 23020 22869	Prior Authorization goes through eviCore

Injection/infusion of neurolytic substance	62282	Prior Authorization goes through eviCore
(e.g., alcohol, phenol, iced saline solutions), with or without other therapeutic substance;		
epidural, lumbar, sacral (caudal)		
Injection(s), of diagnostic or therapeutic	62320	Prior Authorization goes through eviCore
substance(s) (e.g., 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		
Injection(s), of diagnostic or therapeutic	62321	Prior Authorization goes through eviCore
substance(s) (e.g., 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 (i.e., fluoroscopy or CT)		
Injection(s), of diagnostic or therapeutic substance(s) (e.g., anesthetic,	62322	Prior Authorization goes through eviCore
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		
Injection(s), of diagnostic or therapeutic	62323	Prior Authorization goes through eviCore
substance(s) (e.g., 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 (i.e., fluoroscopy or CT)		
Injection(s), including indwelling catheter	62324	Prior Authorization goes through eviCore
placement, continuous infusion or intermittent		The realist East on goes through exicute
bolus, of diagnostic or therapeutic		
substance(s) (e.g., anesthetic,		
antispasmodic, opioid, steroid, other solution), not including neurolytic		
substances, interlaminar epidural or		
subarachnoid, cervical or thoracic; without		
imaging guidance		
Injection(s), including indwelling catheter placement, continuous infusion or intermittent	62325	Prior Authorization goes through eviCore
bolus, of diagnostic or therapeutic		
substance(s) (e.g., anesthetic,		
antispasmodic, opioid, steroid, other		
solution), not including neurolytic substances, interlaminar epidural or		
subarachnoid, cervical or thoracic; with		
imaging guidance (i.e., fluoroscopy or CT)		
Injection(s), including indwelling catheter	62326	Prior Authorization goes through eviCore
placement, continuous infusion or intermittent		
bolus, of diagnostic or therapeutic substance(s) (e.g., anesthetic,		
antispasmodic, opioid, steroid, other		
solution), not including neurolytic		
substances, interlaminar epidural or		
subarachnoid, lumbar or sacral (caudal); without imaging guidance		
Injection(s), including indwelling catheter	62327	Prior Authorization goes through eviCore
placement, continuous infusion or intermittent	DECE.	i noi Authorization guestinough evicore
bolus, of diagnostic or therapeutic		
substance(s) (e.g., anesthetic,		
antispasmodic, opioid, steroid, other solution), not including neurolytic		
substances, interlaminar epidural or		
subarachnoid, lumbar or sacral (caudal); with		
imaging guidance (i.e., fluoroscopy or CT)		
Injection(s), anesthetic agent(s) and/or	64479	Drian Authorization good through oxiCoro
steroid; transforaminal epidural, with imaging	04470	Prior Authorization goes through eviCore
guidance (fluoroscopy or CT), cervical or		
thoracic, single level	04400	
Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging	64480	Prior Authorization goes through eviCore
guidance (fluoroscopy or CT), cervical or		
thoracic, each additional level (List		
separately in addition to code for primary		
procedure) Injection(s), anesthetic agent(s) and/or	64483	Prior Authorization goes through eviCore
steroid; transforaminal epidural, with imaging		The realist East on goes through exicute
guidance (fluoroscopy or CT), lumbar or		
sacral, single level	C4404	Dilas Authoritation and thomas and a sife and
Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging	64484	Prior Authorization goes through eviCore
guidance (fluoroscopy or CT), lumbar or		
sacral, each additional level (List separately		
in addition to code for primary procedure)	64400	Doing Authorization acceptance by a con-
Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or	64490	Prior Authorization goes through eviCore
nerves innervating that joint) with image		
guidance (fluoroscopy or CT), cervical or		
thoracic; single level Injection(s), diagnostic or therapeutic agent,	64491	Drian Authorization good through aviCara
paravertebral facet (zygapophyseal) joint (or		Prior Authorization goes through eviCore
nerves innervating that joint) with image		
guidance (fluoroscopy or CT), cervical or		
thoracic; second level (List separately in addition to code for primary procedure)		
Injection(s), diagnostic or therapeutic agent,	64492	Prior Authorization goes through eviCore
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)		
Injection(s), diagnostic or therapeutic agent,	64493	Prior Authorization goes through eviCore
paravertebral facet (zygapophyseal) joint (or		
nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or		
sacral; single level		
Injection(s), diagnostic or therapeutic agent,	64494	Prior Authorization goes through eviCore
paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image		
LUBLIVES INDERVATING THAT (OINT) WITH IMAGE		1
guidance (fluoroscopy or CT), lumbar or sacral; second level (List separately in		
guidance (fluoroscopy or CT), lumbar or		

Injection(s), diagnostic or therapeutic agent,	64495	Prior Authorization goes through eviCore
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) Destruction by neurolytic agent, paravertebral	64633	a trade that attacks and a trade
facet joint nerve(s), with imaging guidance	04033	Prior Authorization goes through eviCore
(fluoroscopy or CT); cervical or thoracic,		
single facet joint	C4C24	a trade that attacks and a trade
Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance	64634	Prior Authorization goes through eviCore
(fluoroscopy or CT); cervical or thoracic,		
each additional facet joint (List separately in		
addition to code for primary procedure)		
Destruction by neurolytic agent, paravertebral	64635	Prior Authorization goes through eviCore
facet joint nerve(s), with imaging guidance		
(fluoroscopy or CT); lumbar or sacral, single facet joint		
Destruction by neurolytic agent, paravertebral	64636	Prior Authorization goes through eviCore
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)		
Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for	62350	Prior Authorization goes through eviCore
long-term medication administration via an		
external pump or implantable		
reservoir/infusion pump; without laminectomy		
Implantation, revision or repositioning of	62351	Prior Authorization goes through eviCore
tunneled intrathecal or epidural catheter, for		
long-term medication administration via an external pump or implantable		
external pump or implantable reservoir/infusion pump; with laminectomy		
Implantation or replacement of device for	62360	Prior Authorization goes through eviCore
intrathecal or epidural drug infusion;		
subcutaneous reservoir Implantation or replacement of device for	62361	Prior Authorization goes through eviCore
intrathecal or epidural drug infusion;		
nonprogrammable pump		
Implantation or replacement of device for intrathecal or epidural drug infusion;	62362	Prior Authorization goes through eviCore
programmable pump, including preparation of		
pump, with or without programming		
Percutaneous injection of allogeneic cellular and/or tissue- based product, intervertebral	0627T	Prior Authorization goes through eviCore
disc, unilateral or bilateral		
injection, with fluoroscopic guidance, lumbar;		
first level	0628T	
Percutaneous injection of allogeneic cellular and/or tissue-	06281	Prior Authorization goes through eviCore
based product, intervertebral disc, unilateral		
or bilateral injection, with fluoroscopic		
guidance, lumbar; each additional level (List separately in addition to code for		
primary procedure)		
Percutaneous injection of allogeneic cellular	0629T	Prior Authorization goes through eviCore
and/or tissue- based product, intervertebral		
disc, unilateral or bilateral injection, with CT guidance, lumbar; first level		
Percutaneous injection of allogeneic cellular	0630T	Prior Authorization goes through eviCore
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)		
Injection, anesthetic agent; stellate ganglion (cervical sympathetic)	64510	Prior Authorization goes through eviCore
Injection, anesthetic agent; lumbar or	64520	Prior Authorization goes through eviCore
thoracic (paravertebral sympathetic)		
Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including	22526	Prior Authorization goes through eviCore
fluoroscopic guidance; single level		
Percutaneous intradiscal electrothermal	22527	Prior Authorization goes through eviCore
annuloplasty, unilateral or bilateral including fluoroscopic guidance; 1 or more additional		
levels (List separately in addition to code for		
primary procedure)		
Percutaneous lysis of epidural adhesions using solution injection (e.g., hypertonic	62263	Prior Authorization goes through eviCore
saline, enzyme) or mechanical means (e.g.,		
catheter) including radiologic localization		
(includes contrast when administered), multiple adhesiolysis sessions; 2 or more		
days		
Percutaneous lysis of epidural adhesions	62264	Prior Authorization goes through eviCore
using solution injection (e.g., hypertonic		
saline, enzyme) or mechanical means (e.g., catheter) including radiologic localization		
(includes contrast when administered),		
multiple adhesiolysis sessions; 1 day	leanen.	Drive Authorization and the color of Cont
Injection/infusion of neurolytic substance (e.g., alcohol, phenol, iced saline solutions),	62280	Prior Authorization goes through eviCore
with or without other therapeutic substance;		
subarachnoid	I	
Injection procedure for chemonucleolysis, including discography, intervertebral disc,	62292	Prior Authorization goes through eviCore
single or multiple levels, lumbar	<u> </u>	
Injection(s), anesthetic agent(s) and/or	64451	Prior Authorization goes through eviCore
steroid; nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or		
computed tomography)	<u> </u>	
Radiofrequency ablation, nerves innervating	64625	Prior Authorization goes through eviCore
the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)		
Injection procedure for sacroiliac joint;	G0260	Prior Authorization goes through eviCore
provision of anesthetic, steroid and/or other		
therapeutic agent, with or without		
arthrography Percutaneous implantation of neurostimulator	63650	Prior Authorization goes through eviCore
electrode array, epidural		
Laminectomy for implantation of	63655	Prior Authorization goes through eviCore
neurostimulator electrodes, plate/paddle, epidural	<u> </u>	
Insertion or replacement of spinal	63685	Prior Authorization goes through eviCore
neurostimulator pulse generator or receiver, direct or inductive coupling		
Injection procedure for sacroiliac joint,	27096	Prior Authorization goes through eviCore
anesthetic/steroid, with image guidance		
(fluoroscopy or CT) including arthrography	I	
when performed		

Allograft, morselized, or placement of	20930	Prior Authorization goes through eviCore
osteopromotive material, for spine surgery only (List separately in addition to code for		
primary procedure)		
Allograft, structural, for spine surgery only (List separately in addition to code for	20931	Prior Authorization goes through eviCore
primary procedure)		
Autograft for spine surgery only (includes	20936	Prior Authorization goes through eviCore
harvesting the graft); local (e.g., ribs, spinous process, or laminar fragments)		
obtained from same incision (List separately		
in addition to code for primary procedure)	20007	
Autograft for spine surgery only (includes harvesting the graft); morselized (through	20937	Prior Authorization goes through eviCore
separate skin or fascial incision) (List		
separately in addition to code for primary procedure)		
Autograft for spine surgery only (includes	20938	Prior Authorization goes through eviCore
harvesting the graft); structural, bicortical or		
tricortical (through separate skin or fascial incision) (List separately in addition to code		
for primary procedure)		
Electrical stimulation to aid bone healing;	20974	Prior Authorization goes through eviCore
noninvasive (nonoperative) Electrical stimulation to aid bone healing;	20975	Prior Authorization goes through eviCore
invasive (operative)		
Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment;	22214	Prior Authorization goes through eviCore
lumbar		
Percutaneous vertebroplasty (bone biopsy	22510	Prior Authorization goes through eviCore
included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all		
imaging guidance; cervicothoracic		
Percutaneous vertebroplasty (bone biopsy	22511	Prior Authorization goes through eviCore
included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all		
imaging guidance; lumbosacral		
Percutaneous vertebroplasty (bone biopsy included when performed). 1 vertebral body	22512	Prior Authorization goes through eviCore
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)		
Percutaneous vertebral augmentation,	22513	Prior Authorization goes through eviCore
including cavity creation (fracture reduction and bone biopsy included when performed)		
using mechanical device (e.g., kyphoplasty),		
1 vertebral body, unilateral or bilateral		
cannulation, inclusive of all imaging guidance; thoracic		
Percutaneous vertebral augmentation,	22514	Prior Authorization goes through eviCore
including cavity creation (fracture reduction		
and bone biopsy included when performed) using mechanical device (e.g., kyphoplasty),		
1 vertebral body, unilateral or bilateral		
cannulation, inclusive of all imaging guidance;		
lumbar Percutaneous vertebral augmentation,	22515	Prior Authorization goes through eviCore
including cavity creation (fracture reduction		The Mathematical Good through the Control of the Co
and bone biopsy included when performed) Lateral Extracavitary Approach Technique	22532	Prior Authorization goes through wiCore
Arthrodesis Procedures on the Spine	22.002	Prior Authorization goes through eviCore
(Vertebral Column).	00500	
Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare	22533	Prior Authorization goes through eviCore
interspace (other than for decompression);		
lumbar Arthrodesis, lateral extracavitary technique,	22534	Dailes Avabasisation acceptance by a Com-
including minimal discectomy to prepare	22334	Prior Authorization goes through eviCore
interspace (other than for decompression);		
thoracic or lumbar, each additional vertebral segment (List separately in addition to code		
for primary procedure)		
Arthrodesis, anterior interbody, including disc space preparation, discectomy,	22551	Prior Authorization goes through eviCore
osteophytectomy and decompression of		
spinal cord and/or nerve roots; cervical below		
C2 Arthrodesis, anterior interbody, including disc	22552	Prior Authorization goes through eviCore
space preparation, discectomy,		in nor Authorization goes through evictore
osteophytectomy and decompression of		
spinal cord and/or nerve roots; cervical below C2, each additional interspace (List		
separately in addition to code for separate		
procedure)	22554	Bailer A. Ab adirability and Abbailer and All Abbailer and Abbailer and All Abbailer and All Abbailer and All Abbailer and Abbail
Arthrodesis, anterior interbody technique, including minimal discectomy to prepare	22554	Prior Authorization goes through eviCore
interspace (other than for decompression);		
cervical below C2 Arthrodesis, anterior interbody technique,	22558	Brian Authorization good through ouiCore
including minimal discectomy to prepare	22300	Prior Authorization goes through eviCore
interspace (other than for decompression);		
lumbar Arthrodesis, anterior interbody technique,	22585	Prior Authorization goes through eviCore
including minimal discectomy to prepare		Addion zacion goes cinough evicore
interspace (other than for decompression);		
each additional interspace (List separately in addition to code for primary procedure)		
Arthrodesis, posterior or posterolateral	22600	Prior Authorization goes through eviCore
technique, single interspace; cervical below C2 segment		
Arthrodesis, posterior or posterolateral	22612	Prior Authorization goes through eviCore
technique, single interspace; lumbar (with		* *
lateral transverse technique, when performed)		
Arthrodesis, posterior or posterolateral	22614	Prior Authorization goes through eviCore
technique, single interspace; each additional		
interspace (List separately in addition to code for primary procedure)		
Arthrodesis, posterior interbody technique,	22630	Prior Authorization goes through eviCore
including laminectomy and/or discectomy to		
	Ī	
prepare interspace (other than for decompression), single interspace; lumbar		
prepare interspace (other than for decompression), single interspace; lumbar Arthrodesis, posterior interbody technique,	22632	Prior Authorization goes through eviCore
prepare interspace (other than for decompression), single interspace; lumbar Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to	22632	Prior Authorization goes through eviCore
prepare interspace (other than for decompression), single interspace; lumbar Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; each	22632	Prior Authorization goes through eviCore
prepare interspace (other than for decompression), single interspace; lumbar Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for	22632	Prior Authorization goes through eviCore

Arthrodesis, combined posterior or posterolateral technique with posterior	22633	Prior Authorization goes through eviCore
interbody technique including laminectomy		
and/or discectomy sufficient to prepare		
interspace (other than for decompression), single interspace: lumbar		
Arthrodesis, combined posterior or	22634	Prior Authorization goes through eviCore
posterolateral technique with posterior		
interbody technique including laminectomy and/or discectomy sufficient to prepare		
interspace (other than for decompression),		
single interspace; each additional interspace and segment (List separately in addition to		
code for primary procedure)		
Exploration of spinal fusion	22830	Prior Authorization goes through eviCore
Posterior non-segmental instrumentation (eg,	22840	Prior Authorization goes through eviCore
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)		
Internal spinal fixation by wiring of spinous	22841	Prior Authorization goes through eviCore
processes (List separately in addition to code		
for primary procedure) Posterior segmental instrumentation (e.g.,	22842	Prior Authorization goes through eviCore
pedicle fixation, dual rods with multiple hooks		
and sublaminar wires); 3 to 6 vertebral segments (List separately in addition to code		
for primary procedure)		
Posterior segmental instrumentation (e.g.,	22843	Prior Authorization goes through eviCore
pedicle fixation, dual rods with multiple hooks and sublaminar wires); 7 to 12 vertebral		
segments (List separately in addition to code		
for primary procedure) Posterior segmental instrumentation (e.g.,	22844	Prior Authorization goes through eviCore
pedicle fixation, dual rods with multiple hooks		Prior Authorization goes through eviCore
and sublaminar wires); 13 or more vertebral		
segments (List separately in addition to code for primary procedure)		
Anterior instrumentation; 2 to 3 vertebral	22845	Prior Authorization goes through eviCore
segments (List separately in addition to code		
for primary procedure) Anterior instrumentation; 4 to 7 vertebral	22846	Prior Authorization goes through eviCore
segments (List separately in addition to code		
for primary procedure) Anterior instrumentation: 8 or more vertebral	22847	Prior Authorization goes through eviCore
segments (List separately in addition to code	22047	Prior Authorization goes through eviCore
for primary procedure)		
Pelvic fixation (attachment of caudal end of instrumentation to pelvic bony structures)	22848	Prior Authorization goes through eviCore
other than sacrum (List separately in addition		
to code for primary procedure)		
Removal of posterior segmental instrumentation	22852	Prior Authorization goes through eviCore
Insertion of interbody biomechanical	22853	Prior Authorization goes through eviCore
device(s) (e.g., synthetic cage, mesh) with		
integral anterior instrumentation for device anchoring (e.g., screws, flanges), when		
performed, to intervertebral disc space in		
conjunction with interbody arthrodesis, each		
interspace (List separately in addition to code for primary procedure		
Insertion of intervertebral biomechanical	22854	Prior Authorization goes through eviCore
device(s) (e.g., synthetic cage, mesh) with integral anterior instrumentation for device		
anchoring (e.g., 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) Removal of anterior instrumentation	22855	Prior Authorization goes through eviCore
Total disc arthroplasty (artificial disc),	22856	Prior Authorization goes through eviCore
anterior approach, including discectomy with		
end plate preparation (includes osteophytectomy for nerve root or spinal cord		
decompression and microdissection); single		
interspace, cervical	22957	Drigg Authorization good through ouiCore
Total disc arthroplasty (artificial disc), anterior approach, including discectomy to	22857	Prior Authorization goes through eviCore
prepare interspace (other than for		
decompression), single interspace, lumbar Total disc arthroplasty (artificial disc),	22858	Prior Authorization goes through eviCore
anterior approach, including discectomy with		Prior Authorization goes through eviCore
end plate preparation (includes		
osteophytectomy for nerve root or spinal cord decompression and microdissection); second	1	
level, cervical (List separately in addition to		
code for primary procedure)	22050	Drive Authorization asset has selected as if Con-
Insertion of intervertebral biomechanical device(s) (e.g., synthetic cage, mesh,	22859	Prior Authorization goes through eviCore
methylmethacrylate) to intervertebral disc		
space or vertebral body defect without		
interbody arthrodesis, each contiguous defect (List separately in addition to code for		
primary procedure)		
Revision including replacement of total disc arthroplasty (artificial disc), anterior	22861	Prior Authorization goes through eviCore
approach, single interspace; cervical		
Revision including replacement of total disc	22862	Prior Authorization goes through eviCore
arthroplasty (artificial disc), anterior approach, single interspace; lumbar	<u> </u>	<u> </u>
Insertion of interlaminar/interspinous process	22867	Prior Authorization goes through eviCore
stabilization/distraction device, without fusion, including image guidance when		
performed, with open decompression, lumbar;		
single level		
Insertion Of Interlaminar/Interspinous Process Stabilization/Distraction Device.	22868	Prior Authorization goes through eviCore
Without Fusion, Including Image Guidance		
When Performed, With Open Decompression,		
Lumbar; Second Level (List Separately In Addition To Code For Primary Procedure)		
. ,		
	22870	Prior Authorization goes through eviCore
Insertion of interlaminar/interspinous process	22010	
Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image		
stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; second		
stabilization/distraction device, without open decompression or fusion, including image		

Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, any	62287	Prior Authorization goes through eviCore
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		
Endoscopic decompression of spinal cord,	62380	Prior Authorization goes through eviCore
nerve root(s), including laminotomy, partial		
facetectomy, foraminotomy, discectomy and/or excision of herniated intervertebral		
disc, 1 interspace, lumbar		
Laminectomy with exploration and/or decompression of spinal cord and/or cauda	63001	Prior Authorization goes through eviCore
equina, without facetectomy, foraminotomy or		
discectomy (e.g., spinal stenosis), 1 or 2 vertebral segments; cervical		
Laminectomy with exploration and/or	63005	Prior Authorization goes through eviCore
decompression of spinal cord and/or cauda		
equina, without facetectomy, foraminotomy Laminectomy with removal of abnormal facets	63012	Prior Authorization goes through eviCore
and/or pars inter- articularis with		
decompression of cauda equina and nerve roots for spondylolisthesis, lumbar (Gill type		
procedure)		
Laminectomy with exploration and/or decompression of spinal	63015	Prior Authorization goes through eviCore
Laminectomy with exploration and/or	63017	Prior Authorization goes through eviCore
decompression of spinal cord and/or cauda		
equina, without facetectomy, foraminotomy or discectomy (e.g., spinal stenosis), more than		
2 vertebral segments; lumbar		
Laminotomy (hemilaminectomy), with decompression of nerve root(s), including	63020	Prior Authorization goes through eviCore
partial facetectomy, foraminotomy and/or		
excision of herniated intervertebral disc; 1 interspace, cervical		
Laminotomy (hemilaminectomy), with	63030	Prior Authorization goes through eviCore
decompression of nerve root(s), including		
partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1		
interspace, lumbar		
Laminotomy (hemilaminectomy), with decompression of nerve root(s), including	63035	Prior Authorization goes through eviCore
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)		
Laminotomy (hemilaminectomy), with decompression of nerve root(s), including	63040	Prior Authorization goes through eviCore
partial facetectomy, foraminotomy and/or		
excision of herniated intervertebral disc, reexploration, single interspace; cervical		
Laminotomy (hemilaminectomy), with	63042	Prior Authorization goes through eviCore
decompression of nerve root(s), including		
partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc,		
reexploration, single interspace; lumbar		
Laminotomy (hemilaminectomy), with decompression of nerve root(s), including	63043	Prior Authorization goes through eviCore
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)		
Laminotomy (hemilaminectomy), with	63044	Prior Authorization goes through eviCore
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)		
Laminectomy, facetectomy and foraminotomy	63045	Prior Authorization goes through eviCore
(unilateral or bilateral with decompression of		
spinal cord, cauda equina and/or nerve root[s], [e.g., spinal or lateral recess		
stenosis]), single vertebral segment; cervical		
Laminectomy, facetectomy and foraminotomy	63047	Prior Authorization goes through eviCore
(unilateral or bilateral with decompression of		
spinal cord, cauda equina and/or nerve root[s], [e.g., spinal or lateral recess		
stenosis]), single vertebral segment; lumbar		
Laminectomy, facetectomy and foraminotomy	63048	Drier Authorization goes through miCore
(unilateral or bilateral with decompression of		Prior Authorization goes through eviCore
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)	1	
Laminoplasty, cervical, with decompression	63050	Prior Authorization goes through eviCore
of the spinal cord, 2 or more vertebral segments;		
Laminoplasty, cervical, with decompression	63051	Prior Authorization goes through eviCore
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 [e.g., wire, suture, mini- plates], when performed)		
Transpedicular approach with decompression	63056	Prior Authorization goes through eviCore
of spinal cord, equina and/or nerve root(s) (e.g., herniated intervertebral disc), single		
segment; lumbar (including transfacet, or		
lateral extraforaminal approach) (e.g., far		
lateral herniated intervertebral disc)		
	63057	Prior Authorization goes through eviCore
Transpedicular approach with decompression		1
of spinal cord, equina and/or nerve root(s)		
of spinal cord, equina and/or nerve root(s) (e.g., herniated intervertebral disc), single segment; each additional segment, thoracic		
of spinal cord, equina and/or nerve root(s) (e.g., herniated intervertebral disc), single segment; each additional segment, thoracic or lumbar (List separately in addition to code		
of spinal cord, equina and/or nerve root(s) (e.g., herniated intervertebral disc), single segment; each additional segment, thoracic	63075	Prior Authorization goes through eviCore
of spinal cord, equina and/or nerve root(s) (e.g., hemiated interverteral disc), single segment; each additional segment, thoracic or lumbar (List separately in addition to code for primary procedure) Discoctomy, anterior, with decompression of spinal cord and/or nerve root(s), including	63075	Prior Authorization goes through eviCore
of spinal cord, equina and/or nerve root(s) (e.g., hemiated intervertebral disc), single segment; each additional segment, thoracic or lumbar (List separately in addition to code for primary procedure) Discectomy, anterior, with decompression of	63075	Prior Authorization goes through eviCore

Discectomy, anterior, with decompression of	63076	Prior Authorization goes through eviCore
spinal cord and/or nerve root(s), including	00010	Thor Authorization goes through evicore
osteophytectomy; cervical, each additional		
interspace (List separately in addition to code		
for primary procedure)		
Vertebral corpectomy (vertebral body	63081	Prior Authorization goes through eviCore
resection), partial or complete, anterior	03001	Filor Authorization goes through evictore
approach with decompression of spinal cord		
and/or nerve root(s); cervical, single segment		
Vertebral corpectomy (vertebral body	63082	Prior Authorization goes through eviCore
resection), partial or complete, anterior		The value reaction goes through extende
approach with decompression of spinal cord		
and/or nerve root(s); cervical, each additional		
segment (List separately in addition to code		
for primary procedure)		
Removal of total disc arthroplasty (artificial	0095T	Prior Authorization goes through eviCore
disc), anterior approach, each additional		
interspace, cervical (List separately in		
addition to code for primary procedure)		
Revision including replacement of total disc	0098T	Prior Authorization goes through eviCore
arthroplasty (artificial disc), anterior		
approach, each additional interspace,		
cervical (List separately in addition to code		
for primary procedure)		
Removal of total disc arthroplasty, (artificial	0164T	Prior Authorization goes through eviCore
disc), anterior approach, each additional		
interspace, lumbar (List separately in addition		
to code for primary procedure) Arthrodesis, sacroiliac joint, percutaneous,	0775T	Drier Authorization goes through ouiCore
	07731	Prior Authorization goes through eviCore
with image guidance, includes placement of intra-articular implant(s)		
Total disc arthroplasty (artificial disc),	22860	Prior Authorization goes through eviCore
anterior approach, including discectomy to		i noi Authorization goes timough evictore
prepare interspace (other than for		
decompression); second interspace, lumbar		
(List separately in addition to code for		
primary procedure)		
Revision including replacement of total disc	0165T	Prior Authorization goes through eviCore
arthroplasty (artificial disc), anterior		The value reaction goes through execute
approach, each additional interspace, lumbar		
(List separately in addition to code for		
primary procedure)		
Percutaneous laminotomy/laminectomy	0274T	Prior Authorization goes through eviCore
(interlaminar approach) for decompression of		
neural elements, (with or without ligamentous		
resection, discectomy, facetectomy and/or		
foraminotomy), any method, under indirect		
image guidance (e.g., fluoroscopic, CT),		
single or multiple levels, unilateral or bilateral;		
cervical or thoracic		
Percutaneous laminotomy/laminectomy	0275T	Prior Authorization goes through eviCore
(interlaminar approach) for decompression of		
neural elements, (with or without ligamentous		
resection, discectomy, facetectomy and/or		
foraminotomy), any method, under indirect		
image guidance (e.g., fluoroscopic, CT),		
single or multiple levels, unilateral or bilateral;		
lumbar		
Arthrodesis, pre-sacral interbody technique,	22586	Prior Authorization goes through eviCore
including disc space preparation, discectomy,		
with posterior instrumentation, with image		
guidance, includes bone graft when		
performed, L5-S1 interspace		
Arthrodesis, posterior technique, atlas-axis	22595	Prior Authorization goes through eviCore
(C1-C2)	07070	
Arthrodesis, sacroiliac joint, percutaneous or	27279	
minimally invanism (indicate at the college)		Prior Authorization goes through eviCore
minimally invasive (indirect visualization), with		Prior Authorization goes through eviCore
image guidance, includes obtaining bone graft		Prior Authorization goes through eviCore
image guidance, includes obtaining bone graft when performed, and placement of transfixing		Prior Authorization goes through eviCore
image guidance, includes obtaining bone graft when performed, and placement of transfixing device		
image guidance, includes obtaining bone graft when performed, and placement of transfixing device Arthrodesis, open, sacroiliac joint, including	27280	Prior Authorization goes through eviCore Prior Authorization goes through eviCore
image guidance, includes obtaining bone graft when performed, and placement of transfixing device Arthrodesis, open, sacrolliac joint, including obtaining bone graft, including		
image guidance, includes obtaining bone graft when performed, and placement of transfixing device Arthrodesis, open, sacrolliac joint, including obtaining bone graft, including instrumentation, when performed	27280	Prior Authorization goes through eviCore
image guidance, includes obtaining bone graft when performed, and placement of transfixing device Arthrodesis, open, sacrolliac joint, including obtaining bone graft, including		
Image guidance, includes obtaining bone graft when performed, and placement of transfixing device Arthrodesis, open, sacrolliac joint, including obtaining bone graft, including instrumentation, when performed Repair, primary, torn ligament and/or capsule, knee; collateral	27280	Prior Authorization goes through eviCore Prior Authorization goes through eviCore
Image guidance, includes obtaining bone graft when performed, and placement of transfixing device Arthrodesis, open, sacrolliac joint, including obtaining bone graft, including instrumentation, when performed Repair, primary, torn ligament and/or capsule,	27280 27405	Prior Authorization goes through eviCore
Image guidance, includes obtaining bone graft when performed, and placement of transfixing device Arthrodesis, open, sacrollac joint, including obtaining bone graft, including instrumentation, when performed Repair, primary, torn ligament and/or capsule, knee; collateral Laminotomy (hemilaminectomy), with	27280 27405	Prior Authorization goes through eviCore Prior Authorization goes through eviCore
Image guidance, includes obtaining bone graft when performed, and placement of transfixing device Arthrodesis, open, sacrollaic joint, including obtaining bone graft, including instrumentation, when performed Repair, primary, torn igament and/or capsule, knee; collaters knee; collaters of nerve root(s), including decompression of nerve root(s), including	27280 27405	Prior Authorization goes through eviCore Prior Authorization goes through eviCore
Image guidance, includes obtaining bone graft when performed, and placement of transfixing device. Arthrodesis, open, sacrollac joint, including obtaining bone graft, including instrumentation, when performed. Repair, primary, torn ligament and/or capsule, knee; collateral Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and	27280 27405	Prior Authorization goes through eviCore Prior Authorization goes through eviCore
Image guidance, includes obtaining bone graft when performed, and placement of transfixing device Arthrodesis, open, sacrolliac joint, including obtaining bone graft, including instrumentation, when performed Repair, primary, torn ligament and/or capsule, knee; collaters of the compression of nerve root(s), including partial facetectomy, foraminotomy and repair of annular defect with implantation of bone anchored annular closure device,	27280 27405	Prior Authorization goes through eviCore Prior Authorization goes through eviCore
Image guidance, includes obtaining bone graft when performed, and placement of transfixing device Arthrodesis, open, sacrollac joint, including obtaining bone graft, including instrumentation, when performed Repair, primary, torn ligament and/or capsule, knee; collateral 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,	27280 27405	Prior Authorization goes through eviCore Prior Authorization goes through eviCore
Image guidance, includes obtaining bone graft when performed, and placement of transfixing device Arthrodesis, open, sacrolilac joint, including obtaining bone graft, including instrumentation, when performed Repair, primary, torn ligament and/or capsule, knee; collaters on ferror cort(s), including partial facetectomy, foraminotomy and ecompression of nerve root(s), including partial facetectomy, foraminotomy and excision of hermitated interveleral disc, and repair of annular defect with implantation of bone anchored annular closure device, including annular defect measurement, all impaet alignment and sizing assessment, and image alignment and sizing assessment, and image alignment and sizing assessment, and image	27280 27405	Prior Authorization goes through eviCore Prior Authorization goes through eviCore
Image guidance, includes obtaining bone graft when performed, and placement of transfixing device Arthrodesis, open, sacrollac joint, including obtaining bone graft, including instrumentation, when performed Repair, primary, torn ligament and/or capsule, knee; collateral 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,	27280 27405	Prior Authorization goes through eviCore Prior Authorization goes through eviCore
Image guidance, includes obtaining bone graft when performed, and placement of transfixing device Arthrodesis, open, sacrolilac joint, including obtaining bone graft, including instrumentation, when performed Repair, primary, torn ligament and/or capsule, knee; collaters on fener corol(s), including partial facetectomy, foraminotomy and eccompression of nerve root(s), including partial facetectomy, foraminotomy and excision of hernitated interverberal 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	27280 27405 C9757	Prior Authorization goes through eviCore Prior Authorization goes through eviCore
Image guidance, includes obtaining bone graft when performed, and placement of transfixing device Arthrodesis, open, sacrolilac joint, including obtaining bone graft, including instrumentation, when performed Repair, primary, torn ligament and/or capsule, knee; collaters on ferror cort(s), including partial facetectomy, foraminotomy and ecompression of nerve root(s), including partial facetectomy, foraminotomy and excision of hermitated interveleral disc, and repair of annular defect with implantation of bone anchored annular closure device, including annular defect measurement, all impaet alignment and sizing assessment, and image alignment and sizing assessment, and image alignment and sizing assessment, and image	27280 27405	Prior Authorization goes through eviCore Prior Authorization goes through eviCore
Image guidance, includes obtaining bone graft when performed, and placement of transfixing device Arthrodesis, open, sacrolilac joint, including obtaining bone graft, including obtaining bone graft, including instrumentation, when performed Repair, primary, torn ligament and/or capsule, knee; collateral Laminotomy (hemiliamisectomy), with decompression of nervie roofto), including partial facetectomy, foraminotomy and excision of hemiliated intervertebral disc, and repair of annular defect with implantation of bone anchored annular closure device, including amular defect was susceptional including annular defect measurement, alignment and sizing assessment, and image guidance; interspace, lumbar. Osteogenesis stimulator, electrical,	27280 27405 C9757	Prior Authorization goes through eviCore Prior Authorization goes through eviCore Prior Authorization goes through eviCore
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