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.

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	59841	Prior authorization is required, elective abortions are not covered.
Induced abortion, by 1 or more intra-amniotic injections (amniocentesis-injections), including hospital admission and visits, delivery of fetus and secundines;	59850	Prior authorization is required, elective abortions are not covered.
Induced abortion, by 1 or more intra-amniotic injections (amniocentesis-injections), including hospital admission and visits, delivery of fetus and secundines; with dilation and curettage and/or evacuation	59851	Prior authorization is required, elective abortions are not covered.
Induced abortion, by 1 or more intra-amniotic injections (amniocentesis-injections), including hospital admission and visits, delivery of fetus and secundines; with hysterotomy (failed intra-amniotic injection)	59852	Prior authorization is required, elective abortions are not covered.
Induced abortion, by 1 or more vaginal suppositories (eg, prostaglandin) with or without cervical dilation (eg, laminaria), including hospital admission and visits, delivery of fetus and secundines;	59855	Prior authorization is required, elective abortions are not covered.
Induced abortion, by 1 or more vaginal 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	59856	Prior authorization is required, elective abortions are not covered.
Induced abortion, by 1 or more vaginal 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)	59857	Prior authorization is required, elective abortions are not covered.
Multifetal pregnancy reduction(s) (MPR)	59866	Prior authorization is required, elective abortions are not covered.
Medically induced abortion by oral ingestion 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	S0199	Prior authorization is required, elective abortions are not covered.
Induced abortion, 17 to 24 weeks	S2260	Prior authorization is required, elective abortions are not covered.
Induced abortion, 25 to 28 weeks	S2265	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	S2267	Prior authorization is required, elective abortions are not covered.
Sterilization	**Codes**	**Prior Authorization Requirement**
Vasotomy, cannulization with or without incision of vas, unilateral or bilateral (separate procedure)	55200	For members 21 and older, a signed consent or awareness form is required with prior authorization.
Vasectomy, unilateral or bilateral (separate procedure), including postoperative semen examination(s)	55250	For members 21 and older, a signed consent or awareness form is required with prior authorization.
Vasotomy for vasograms, seminal vesiculograms, or epididymograms, unilateral or bilateral	55300	For members 21 and older, a signed consent or awareness form is required with prior authorization.
Ligation or transection of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral	58600	For members 21 and older, a signed consent or awareness form is required with prior authorization.
Ligation or transection of fallopian tube(s), abdominal or vaginal approach, postpartum, unilateral or bilateral, during same hospitalization (separate procedure)	58605	For members 21 and older, a signed consent or awareness form is required with prior authorization.
Ligation or transection of fallopian tube(s) when done at the time of cesarean delivery or intra-abdominal surgery (not a separate procedure) (List separately in addition to code for primary procedure)	58611	For members 21 and older, a signed consent or awareness form is required with prior authorization.
Laparoscopy, surgical; with occlusion of oviducts by device (eg, band, clip, or Falope ring)	58671	For members 21 and older, a signed consent or awareness form is required with prior authorization.
Hysterectomy	**Codes**	**Prior Authorization Requirement**
Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s);	58150	Prior authorization is required, medical necessity criteria must be met.
Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s); with colpo-urethrocystopexy (eg, Marshall-Marchetti-Krantz, Burch)	58152	Prior authorization is required, medical necessity criteria must be met.
Supracervical abdominal hysterectomy (subtotal hysterectomy), with or without removal of tube(s), with or without removal of ovary(s)	58180	Prior authorization is required, medical necessity criteria must be met.
Total abdominal hysterectomy, including partial vaginectomy, with para-aortic and pelvic lymph node sampling, with or without removal of tube(s), with or without removal of ovary(s)	58200	Prior authorization is required, medical necessity criteria must be met.
Radical abdominal hysterectomy, with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy), with or without removal of tube(s), with or without removal of ovary(s)	58210	Prior authorization is required, medical necessity criteria must be met.
Pelvic exenteration for gynecologic malignancy, with total abdominal hysterectomy or cervicectomy, with or 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	58240	Prior authorization is required, medical necessity criteria must be met.
Vaginal hysterectomy, for uterus 250 g or less;	58260	Prior authorization is required, medical necessity criteria must be met.
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.
Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s), with repair of enterocele	58263	Prior authorization is required, medical necessity criteria must be met.
Vaginal hysterectomy, for uterus 250 g or less; with colpo-urethrocystopexy (Marshall-Marchetti-Krantz type, Pereyra type) with or without endoscopic control	58267	Prior authorization is required, medical necessity criteria must be met.

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 vaginectomy; with repair of enterocele	58280	Prior authorization is required, medical necessity criteria must be met.
Vaginal hysterectomy, radical (Schauta type operation)	58285	Prior authorization is required, medical necessity criteria must be met.
Vaginal hysterectomy, for uterus greater than 250 g;	58290	Prior authorization is required, medical necessity criteria must be met.
Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)	58291	Prior authorization is required, medical necessity criteria must be met.
Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s), with repair of enterocele	58292	Prior 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 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	33945	Prior authorization is required.
Bone marrow harvesting for transplantation; allogeneic	38230	Prior authorization is required.
Bone marrow harvesting for transplantation; autologous	38232	Prior authorization is required.
Allogeneic lymphocyte infusions	38242	Prior authorization is required.
Liver allotransplantation, orthotopic, partial or whole, from cadaver or living donor, any age	47135	Prior authorization is required.
Pancreatectomy, total or subtotal, with autologous transplantation of pancreas or pancreatic islet cells	48160	Prior authorization is required.
Donor pancreatectomy (including cold preservation), with or without duodenal segment for transplantation	48550	Prior authorization is required.
Transplantation of pancreatic allograft	48554	Prior authorization is required.
Removal of transplanted pancreatic allograft	48556	Prior authorization is required.
Renal allotransplantation, implantation of graft; without recipient nephrectomy	50360	Prior authorization is required.
Renal allotransplantation, implantation of graft; with recipient nephrectomy	50365	Prior authorization is required.
Removal of transplanted renal allograft	50370	Prior authorization is required.
Renal autotransplantation, reimplantation of kidney	50380	Prior authorization is required.
Keratoplasty (corneal transplant); anterior lamellar	65710	Prior authorization is required.
Keratoplasty (corneal transplant); penetrating (except in aphakia or pseudophakia)	65730	Prior authorization is required.
Keratoplasty (corneal transplant); penetrating (in aphakia)	65750	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 portal vein catheterization and infusion	G0341	Prior authorization is required.
Transplantation of small intestine and liver allografts	S2053	Prior authorization is required.
Transplantation of multivisceral organs	S2054	Prior authorization is required.
Lobar lung transplantation	S2060	Prior authorization is required.
Donor lobectomy (lung) for transplantation, living donor	S2061	Prior authorization is required.
Simultaneous pancreas kidney transplantation	S2065	Prior authorization is required.
Islet cell tissue transplant from pancreas; allogeneic	S2102	Prior authorization is required.
Bone marrow or blood-derived stem cells (peripheral or umbilical), allogeneic or autologous, harvesting, transplantation, and related complications; including: pheresis and cell preparation/storage; marrow ablative therapy; drugs, supplies, hospitalization with outpatient follow-up; medical/surgical, diagnostic, emergency, and rehabilitative services; and the number of days of pre- and posttransplant care in the global definition	S2150	Prior authorization is required.
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	S2152	Prior authorization is required.
Bony Impacted Wisdom Teeth	**Codes**	**Prior Authorization Requirement**
IMPACT TOOTH REMOV PART BONY	D7230	Prior authorization is required.
IMPACT TOOTH REMOV COMP BONY	D7240	Prior authorization is required.
IMPACT TOOTH REM BONY W/COMP	D7241	Prior authorization is required.
Home Health	**Codes**	**Prior Authorization Requirement**
Policy Forthcoming		
Hospice	**Codes**	**Prior Authorization Requirement**

Hospice Service-Routine Home Care	0651	Prior authorization is required.
Hospice Service-Continuous Home Care	0652	Prior authorization is required.
Hospice Service-Inpatient Respite Care	0655	Prior authorization is required.
Hospice Service-General Inpatient Care Nonrespite	0656	Prior authorization is required.
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, HHO-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, 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 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 outpatient 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 decision 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	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.
Radiologic examination, spine, cervical; 2 or 3 views	72040	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, cervical; 4 or 5 views	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.
Radiologic examination, spine, cervical; 6 or more views	72052	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; thoracic, 2 views	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.
Radiologic examination, spine; thoracic, 3 views	72072	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; thoracic, minimum of 4 views	72074	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; thoracolumbar junction, minimum of 2 views	72080	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 evaluation); 1 view	72081	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 evaluation); 2 or 3 views	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.
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 evaluation); minimum of 6 views	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.
Radiologic examination, spine, lumbosacral; 2 or 3 views	72100	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, 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 be prior authorized. Please refer to Chiropractic Benefit and Services Policy, HHO-RP-1120.
Radiologic examination, spine, lumbosacral; complete, including bending views, minimum of 6 views	72114	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, lumbosacral; bending views only, 2 or 3 views	72120	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, 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 be prior authorized. Please refer to Chiropractic Benefit and Services Policy, HHO-RP-1120.
Radiologic examination, pelvis; complete, 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 than 3 views	72200	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; 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 be prior authorized. Please refer to Chiropractic Benefit and Services Policy, HHO-RP-1120.
Radiologic examination, sacrum and coccyx, minimum of 2 views	72220	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.
Facility-Based Behavioral Health Services	**Codes**	**Prior Authorization Requirement**
Inpatient (IP) Acute Psychiatric	0114	Prior authorization is required. Please refer to Facility-Based Behavioral Health Services, HHO-RP-1005.
Inpatient (IP) Acute Psychiatric (semi-private two bed)	0124	Prior authorization is required. Please refer to Facility-Based Behavioral Health Services, HHO-RP-1005.
Behavioral Health Treatment/Services-Extension of 090X-Partial HospitalizationLess Intensive	0912	Prior authorization is required. Please refer to Facility-Based Behavioral Health Services, HHO-RP-1005.
Behavioral Health Treatment/Services-Extension of 090X-Partial HospitalizationIntensive	0913	Prior authorization is required. Please refer to Facility-Based Behavioral Health Services, HHO-RP-1005.
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 I	0191	Prior authorization is required. Skilled nursing benefit is up to 30 calendar days.
Subacute Care-Level II	0192	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 compensation	77522	Prior authorization is required.
Proton treatment delivery; intermediate	77523	Prior authorization is required.
Proton treatment delivery; complex	77525	Prior authorization is required.
Scleral application of tantalum ring(s) for localization of lesions for proton beam therapy	S8030	Prior authorization is required.
IMRT (Intensity Modulated Radiation Therapy)	**Codes**	**Prior Authorization Requirement**
Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; simple	77385	Prior authorization is required.
Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; complex	77386	Prior authorization is required.
Intensity modulated treatment delivery, single or multiple fields/arcs, via narrow spatially and temporally modulated beams, binary, dynamic MLC, per treatment session	G6015	Prior authorization is required.
Radiation Therapy	**Codes**	**Prior Authorization Requirement**
Radiation treatment management, 5 treatments	77427	Prior authorization is required for conditions other than cancer.
Radiation therapy management with complete course of therapy consisting of 1 or 2 fractions only	77431	Prior authorization is required for conditions other than cancer.
Stereotactic radiation treatment management of cranial lesion(s) (complete course of treatment consisting of 1 session)	77432	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	77435	Prior authorization is required for conditions other than cancer.
Intraoperative radiation treatment management	77469	Prior authorization is required for conditions other than cancer.
Special treatment procedure (eg, total body irradiation, hemibody radiation, per oral or endocavitary irradiation)	77470	Prior authorization is required for conditions other than cancer.
Radiation treatment delivery, superficial and/or ortho voltage, per day	77401	Prior authorization is required for conditions other than cancer.
Radiation treatment delivery, => 1 MeV; simple	77402	Prior authorization is required for conditions other than cancer.
Radiation treatment delivery, => 1 MeV; intermediate	77407	Prior authorization is required for conditions other than cancer.
Radiation treatment delivery, => 1 MeV; complex	77412	Prior authorization is required for conditions other than cancer.
Therapeutic radiology port image(s)	77417	Prior authorization is required for conditions other than cancer.
Guidance for localization of target volume for delivery of radiation treatment, includes intrafraction tracking, when performed	77387	Prior authorization is required for conditions other than cancer.
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)	77423	Prior authorization is required for conditions other than cancer.
Intraoperative radiation treatment delivery, x-ray, single treatment session	77424	Prior authorization is required for conditions other than cancer.
Intraoperative radiation treatment delivery, electrons, single treatment session	77425	Prior authorization is required for conditions other than cancer.
Intracavitary radiation source application; simple	77761	Prior authorization is required for conditions other than cancer.
Intracavitary radiation source application; intermediate	77762	Prior authorization is required for conditions other than cancer.
Intracavitary radiation source application; complex	77763	Prior authorization is required for conditions other than cancer.
Interstitial radiation source application, complex, includes supervision, handling, loading of radiation source, when performed	77778	Prior authorization is required for conditions other than cancer.
Insertion of a vaginal radiation afterloading apparatus for clinical brachytherapy	57156	Prior authorization is required for conditions other than cancer.
Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; multi-source Cobalt 60 based	77371	Prior authorization is required for conditions other than cancer.

Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; linear accelerator based	77372	Prior authorization is required for conditions other than cancer.
Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions	77373	Prior authorization is required for conditions other than cancer.
Unlisted procedure, medical radiation physics, dosimetry and treatment devices, and special services	77399	Prior authorization is required for conditions other than cancer.
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 therapy	G6002	Prior authorization is required for conditions other than cancer.
Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks: up to 5 mev	G6003	Prior authorization is required for conditions other than cancer.
Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks: 6-10 mev	G6004	Prior authorization is required for conditions other than cancer.
Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks: 11-19 mev	G6005	Prior authorization is required for conditions other than cancer.
Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks: 20 mev or greater	G6006	Prior authorization is required for conditions other than cancer.
Radiation treatment delivery, two separate treatment areas, three or more ports on a single treatment area, use of multiple blocks: up to 5 mev	G6007	Prior authorization is required for conditions other than cancer.
Radiation treatment delivery, two separate treatment areas, three or more ports on a single treatment area, use of multiple blocks: 6-10 mev	G6008	Prior authorization is required for conditions other than cancer.
Radiation treatment delivery, two separate treatment areas, three or more ports on a single treatment area, use of multiple blocks: 11-19 mev	G6009	Prior authorization is required for conditions other than cancer.
Radiation treatment delivery, two separate treatment areas, three or more ports on a single treatment area, use of multiple blocks: 20 mev or greater	G6010	Prior authorization is required for conditions other than cancer.
Radiation treatment delivery, three or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; up to 5 mev	G6011	Prior authorization is required for conditions other than cancer.
Radiation treatment delivery, three or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 6-10 mev	G6012	Prior authorization is required for conditions other than cancer.
Radiation treatment delivery, three or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 11-19 mev	G6013	Prior authorization is required for conditions other than cancer.
Radiation treatment delivery, three or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 20 mev or greater	G6014	Prior authorization is required for conditions other than cancer.
Compensator-based beam modulation treatment delivery of inverse planned treatment using three or more high resolution (milled or cast) compensator, convergent beam modulated fields, per treatment session	G6016	Prior authorization is required for conditions other than cancer.
Intra-fraction localization and tracking of target or patient motion during delivery of radiation therapy (e.g., 3D positional tracking, gating, 3D surface tracking), each fraction of treatment	G6017	Prior authorization is required for conditions other than cancer.

Cosmetic Procedures	Codes	Prior Authorization Requirement
Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.0 sq cm or less	11920	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met.
Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.1 to 20.0 sq cm	11921	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met.
Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; each additional 20.0 sq cm, or part thereof (List separately in addition to code for primary procedure)	11922	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met.
Subcutaneous injection of filling material (eg, collagen); 1 cc or less	11950	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met.
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.
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.
Subcutaneous injection of filling material (eg, collagen); over 10.0 cc	11954	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met.
Implantation of biologic implant (eg, acellular dermal matrix) for soft tissue reinforcement (ie, breast, trunk) (List separately in addition to code for primary procedure)	15777	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met.
Blepharoplasty, lower eyelid;	15820	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met.
Blepharoplasty, lower eyelid; with extensive herniated fat pad	15821	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met.
Blepharoplasty, upper eyelid;	15822	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met.
Blepharoplasty, upper eyelid; with excessive skin weighting down lid	15823	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met.
Suction assisted lipectomy; trunk	15877	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met.
Suction assisted lipectomy; upper extremity	15878	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met.
Suction assisted lipectomy; lower extremity	15879	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met.
Mastopexy	19316	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met.

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 must be met.
Removal of ruptured breast implant, including implant contents (eg, saline, silicone gel)	19330	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria 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 expansion(s)	19357	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met.
Breast reconstruction; with latissimus dorsi flap	19361	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met.
Breast reconstruction; with free flap (eg, fTRAM, DIEP, SIEA, GAP flap)	19364	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 (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 (TRAM) flap, requiring separate microvascular anastomosis (supercharging)	19368	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met.
Breast reconstruction; with bipedicled transverse rectus abdominis myocutaneous (TRAM) flap	19369	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met.
Revision of peri-implant capsule, breast, including capsulotomy, capsulorrhaphy, and/or partial capsulectomy	19370	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria 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 and/or re-inset of flaps in autologous reconstruction or significant capsular revision combined with soft tissue excision in implant-based reconstruction)	19380	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met.
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 cartilages, and/or elevation of nasal tip	30410	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met.
Rhinoplasty, primary; including major septal repair	30420	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met.
Rhinoplasty, secondary; minor revision (small amount of nasal tip work)	30430	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)	30435	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 columellar lengthening; tip only	30460	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 columellar lengthening; tip, septum, osteotomies	30462	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met.
Repair of nasal vestibular stenosis (eg, spreader grafting, lateral nasal wall reconstruction)	30465	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met.
Repair of nasal valve collapse with subcutaneous/submucosal lateral wall implant(s)	30468	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria 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.
Repair choanal atresia; intranasal	30540	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met.
Repair choanal atresia; transpalatine	30545	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met.
Lysis intranasal synechia	30560	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met.
Repair fistula; oromaxillary (combine with 31030 if antrotomy is included)	30580	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met.
Repair fistula; oronasal	30600	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met.
Septal or other intranasal dermatoplasty (does not include obtaining graft)	30620	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria 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 must be met.
Injection, incobotulinumtoxinA, 1 unit	J0588	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met.
Implantable breast prosthesis, silicone or equal	L8600	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met.
Punch graft for hair transplant; 1 to 15 punch grafts	15775	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met.
Punch graft for hair transplant; more than 15 punch grafts	15776	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria 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.

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 removal)	15783	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met.
Abrasion; single lesion (eg, keratosis, scar)	15786	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met.
Abrasion; each additional 4 lesions or less (List separately in addition to code for primary procedure)	15787	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 must be met.
Chemical peel, facial; dermal	15789	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met.
Chemical peel, nonfacial; epidermal	15792	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met.
Chemical peel, nonfacial; dermal	15793	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 (platysmal flap, P-flap)	15825	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met.
Rhytidectomy; glabellar frown lines	15826	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met.
Rhytidectomy; cheek, chin, and neck	15828	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, infraumbilical panniculectomy	15830	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); thigh	15832	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); 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 must be met.
Excision, excessive skin and subcutaneous tissue (includes lipectomy); arm	15836	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); forearm or hand	15837	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); 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)	S0800	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met.
Photorefractive keratectomy (PRK)	S0810	Cosmetic procedures are a non-covered service. Prior authorization is required, medical necessity criteria must be met.
Mental Health and Substance Abuse Inpatient 18+	**Codes**	**Prior Authorization Requirement**
Alcohol and/or other drug treatment program, per diem	H2036	A prior authorization is required. Members must be 18 and older, with a behavioral health diagnosis.
Alcohol and/or drug abuse halfway house services, per diem	H2034	A prior authorization is required. Members must be 18 and older, with a behavioral health diagnosis.
Mental Health and Substance Use Partial Hospitalization	**Codes**	**Prior Authorization Requirement**
Mental health partial hospitalization, treatment, less than 24 hours	H0035	A prior authorization is required. Members must have a behavorial health diagnosis.
Substance Abuse Intensive Outpatient Treatment	**Codes**	**Prior Authorization Requirement**
Alcohol and/or drug services; intensive outpatient (treatment program that operates at least 3 hours/day and at least 3 days/week and is based on an individualized treatment plan), including assessment, counseling; crisis intervention, and activity therapies or education	H0015	A prior authorization is required. Members must have a behavorial health diagnosis.
Breast Pumps	**Codes**	**Prior Authorization Requirement**
Breast pump, hospital grade, electric (AC and/or DC), any type	E0604	Prior authorization is required.
Bone Growth Stimulator	**Codes**	**Prior Authorization Requirement**
Low intensity ultrasound stimulation to aid bone healing, noninvasive (nonoperative)	20979	Prior authorization is required
Osteogenesis stimulator, electrical, noninvasive, other than spinal applications	E0747	Prior authorization is required
Osteogenesis stimulator, low intensity ultrasound, noninvasive	E0760	Prior authorization is required
Joint Replacement	**Codes**	**Prior Authorization Requirement**
Arthroplasty, patella; without prosthesis	27437	Prior authorization is required.
Arthroplasty, knee, hinge prosthesis (eg, Walldius type)	27445	Prior authorization is required.
Spinal Neuro Stimulator/Surgeries	**Codes**	**Prior Authorization Requirement**
Open treatment of rib fracture(s) with internal fixation, includes thoracoscopic visualization when performed, unilateral; 4-6 ribs	21812	Prior authorization is required.
TMJ Surgery	**Codes**	**Prior Authorization Requirement**
Arthrotomy, temporomandibular joint	21010	Prior authorization is required.
Condylectomy, temporomandibular joint (separate procedure)	21050	Prior authorization is required.
Meniscectomy, partial or complete, temporomandibular joint (separate procedure)	21060	Prior authorization is required.
Coronoidectomy (separate procedure)	21070	Prior authorization is required.
Manipulation of temporomandibular joint(s) (TMJ), therapeutic, requiring an anesthesia service (ie, general or monitored anesthesia care)	21073	Prior authorization is required.
Injection procedure for temporomandibular joint arthrography	21116	Prior authorization is required.
Arthroplasty, temporomandibular joint, with or without autograft (includes obtaining graft)	21240	Prior authorization is required.
Arthroplasty, temporomandibular joint, with allograft	21242	Prior authorization is required.

Closed treatment of temporomandibular dislocation; initial or subsequent	21480	Prior authorization is required.
Closed treatment of temporomandibular dislocation; complicated (eg, recurrent requiring intermaxillary fixation or splinting), initial or subsequent	21485	Prior authorization is required.
Open treatment of temporomandibular dislocation	21490	Prior authorization is required.
Arthroscopy, temporomandibular joint, diagnostic, with or without synovial biopsy (separate procedure)	29800	Prior authorization is required.
Arthroscopy, temporomandibular joint, surgical	29804	Prior authorization is required.
Vagus Nerve Stimulation	**Codes**	**Prior Authorization Requirement**
Vagotomy including pyloroplasty, with or without gastrostomy; truncal or selective	43640	Prior authorization is required.
Vagotomy including pyloroplasty, with or without gastrostomy; parietal cell (highly selective)	43641	Prior authorization is required.
Laparoscopy, surgical; transection of vagus nerves, truncal	43651	Prior authorization is required.
Laparoscopy, surgical; transection of vagus nerves, selective or highly selective	43652	Prior authorization is required.
Injection(s), anesthetic agent(s) and/or steroid; vagus nerve	64408	Prior authorization is required.
Open implantation of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator	64568	Prior authorization is required.
Revision or replacement of cranial nerve (eg, vagus nerve) neurostimulator electrode array, including connection to existing pulse generator	64569	Prior authorization is required.
Removal of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator	64570	Prior authorization is required.
Transection or avulsion of; vagus nerves limited to proximal stomach (selective proximal vagotomy, proximal gastric vagotomy, parietal cell vagotomy, supra- or highly selective vagotomy)	64755	Prior authorization is required.
Transection or avulsion of; vagus nerve (vagotomy), abdominal	64760	Prior authorization is required.
Vagus nerve blocking therapy (morbid obesity); laparoscopic implantation of neurostimulator electrode array, anterior and posterior vagal trunks adjacent to esophagogastric junction (EGJ), with implantation of pulse generator, includes programming	0312T	Prior authorization is required.
Vagus nerve blocking therapy (morbid obesity); laparoscopic revision or replacement of vagal trunk neurostimulator electrode array, including connection to existing pulse generator	0313T	Prior authorization is required.
Vagus nerve blocking therapy (morbid obesity); laparoscopic removal of vagal trunk neurostimulator electrode array and pulse generator	0314T	Prior authorization is required.
Vagus nerve blocking therapy (morbid obesity); removal of pulse generator	0315T	Prior authorization is required.
Vagus nerve blocking therapy (morbid obesity); replacement of pulse generator	0316T	Prior authorization is required.
Vagus nerve blocking therapy (morbid obesity); neurostimulator pulse generator electronic analysis, includes reprogramming when performed	0317T	Prior authorization is required.
Vein Procedures	**Codes**	**Prior Authorization Requirement**
Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; first vein treated	36473	Prior authorization is required.
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)	36474	Prior authorization is required.
Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated	36475	Prior authorization is required.
Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated	36478	Prior authorization is required.
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)	36479	Prior authorization is required.
Ligation and division of long saphenous vein at saphenofemoral junction, or distal interruptions	37700	Prior authorization is required.
Ligation, division, and stripping, short saphenous vein	37718	Prior authorization is required.
Ligation, division, and stripping, long (greater) saphenous veins from saphenofemoral junction to knee or below	37722	Prior authorization is required.
Ligation and division and complete stripping of long or short saphenous veins with radical excision of ulcer and skin graft and/or interruption of communicating veins of lower leg, with excision of deep fascia	37735	Prior authorization is required.
Ligation of perforator veins, subfascial, radical (Linton type), including skin graft, when performed, open,1 leg	37760	Prior authorization is required.
Ligation of perforator vein(s), subfascial, open, including ultrasound guidance, when performed, 1 leg	37761	Prior authorization is required.
Stab phlebectomy of varicose veins, 1 extremity; 10-20 stab incisions	37765	Prior authorization is required.
Stab phlebectomy of varicose veins, 1 extremity; more than 20 incisions	37766	Prior authorization is required.
Ligation and division of short saphenous vein at saphenopopliteal junction (separate procedure)	37780	Prior authorization is required.
Ligation, division, and/or excision of varicose vein cluster(s), 1 leg	37785	Prior authorization is required.

Long Term Acute Care (LTAC)	Codes	Prior Authorization Requirement
Room & Board Semiprivate (Two Beds)-General Classification	0120	Prior authorization is required and member must meet medical necessity criteria. Concurrent reviews are required every 3-7 days.
Medical Drug Management	**Codes**	**Prior Authorization Requirement**
Injection, abatacept, 10 mg (code may be used for medicare when drug administered under the direct supervision of a physician, not for use when drug is self administered	J0129	Prior Authorization is required.
Injection, abobotulinumtoxina, 5 units	J0586	Prior Authorization is required.
Injection, adalimumab, 20 mg	J0135	Prior Authorization is required.
Injection, aducanumab-avwa, 2 mg	J0172	Prior Authorization is required.
Injection, aflibercept, 1 mg	J0178	Prior Authorization is required.
Injection, agalsidase beta, 1 mg	J0180	Prior Authorization is required.
Injection, alglucosidase alfa, (lumizyme), 10 mg	J0221	Prior Authorization is required.
Injection, alpha 1 proteinase inhibitor (human), (glassia), 10 mg	J0257	Prior Authorization is required.
Injection, alpha 1 proteinase inhibitor (human), not otherwise specified, 10 mg	J0256	Prior Authorization is required.
Unclassified biologics Injection, anifrolumab-fnia, 1 mg	J0491	Prior Authorization is required.
Injection, factor viii (antihemophilic factor, recombinant) (xyntha), per i.u.	J7185	Prior Authorization is required.
Injection, von willebrand factor complex (human), wilate, 1 i.u. vwf:rco	J7183	Prior Authorization is required.
Injection, factor viii fc fusion protein (recombinant), per iu	J7205	Prior Authorization is required.
Injection, von willebrand factor complex (humate-p), per iu vwf:rco	J7187	Prior Authorization is required.
Injection, antihemophilic factor viii/von willebrand factor complex (human), per factor viii i.u.	J7186	Prior Authorization is required.
Injection, avalglucosidase alfa-ngpt, 4 mg	J0219	Prior Authorization is required.
Injection, belimumab, 10 mg	J0490	Prior Authorization is required.
Injection, benralizumab, 1 mg	J0517	Prior Authorization is required.
Injection, betamethasone acetate 3 mg and betamethasone sodium phosphate 3 mg	J0702	Prior Authorization is required.
Injection, bevacizumab, 10 mg	J9035	Prior Authorization is required.
Injection, bimatoprost, intracameral implant, 1 microgram	J7351	Prior Authorization is required.
Injection, brexanolone, 1 mg	J1632	Prior Authorization is required.
Injection, buprenorphine extended-release (sublocade), **less than or equal to 100 mg**	Q9991	Prior Authorization is required.
Injection, buprenorphine extended-release (sublocade), **greater than 100 mg**	Q9992	Prior Authorization is required.
Injection, burosumab-twza, 1 mg	J0584	Prior Authorization is required.
Injection, c-1 esterase inhibitor (human), berinert, 10 units	J0597	Prior Authorization is required.
Injection, c-1 esterase inhibitor (human), cinryze, 10 units	J0598	Prior Authorization is required.
Injection, c1 esterase inhibitor (recombinant), ruconest, 10 units	J0596	Prior Authorization is required.
Injection, casimersen, 10 mg	J1426	Prior Authorization is required.
Injection, cerliponase alfa, 1 mg	J0567	Prior Authorization is required.
Injection, certolizumab pegol, 1 mg (code may be used for medicare when drug administered under the direct supervision of a physician, not for use when drug is self administered)	J0717	Prior Authorization is required.
Factor viia (antihemophilic factor, recombinant), per 1 microgram	J7189	Prior Authorization is required.
Injection, collagenase, clostridium histolyticum, 0.01 mg	J0775	Prior Authorization is required.
Injection, crizanlizumab-tmca, 5 mg	J0791	Prior Authorization is required.
Injection, darbepoetin alfa, 1 microgram (**non-esrd use**)	J0881	Prior Authorization is required.
Injection, darbepoetin alfa, 1 microgram (**for esrd on dialysis**)	J0882	Prior Authorization is required.
Injection, denosumab, 1 mg	J0897	Prior Authorization is required.
Injection, eculizumab, 10 mg	J1300	Prior Authorization is required.
Injection, edaravone, 1 mg	J1301	Prior Authorization is required.
Injection, elosulfase alfa, 1 mg	J1322	Prior Authorization is required.
Injection, emapalumab-lzsg, 1 mg	J9210	Prior Authorization is required.
Injection, emicizumab-kxwh, 0.5 mg	J7170	Prior Authorization is required.
Injection, epoetin alfa, (**for non-esrd use**) 1000 units	J0885	Prior Authorization is required.
Injection, epoetin alfa, 100 units (**for esrd on dialysis**)	Q4081	Prior Authorization is required.
Injection, epoetin alfa, (for non-esrd use), 1000 units	J0885	Prior Authorization is required.
Injection, epoetin alfa, 100 units (for esrd on dialysis)	Q4081	Prior Authorization is required.
Injection, epoetin beta, 1 microgram, (**for esrd on dialysis**)	J0887	Prior Authorization is required.
Injection, epoetin beta, 1 microgram, (**for non esrd use**)	J0888	Prior Authorization is required.
Injection, epoprostenol, 0.5 mg	J1325	Prior Authorization is required.
Injection, eptinezumab-jjmr, 1 mg	J3032	Prior Authorization is required.
Esketamine, nasal spray, 1 mg	S0013	Prior Authorization is required.
Injection, eteplirsen, 10 mg	J1428	Prior Authorization is required.
Injection, evinacumab-dgnb, 5 mg	J1305	Prior Authorization is required.
Factor viii (antihemophilic factor, recombinant) per i.u., not otherwise specified	J7192	Prior Authorization is required.
Injection, ferric carboxymaltose, 1 mg	J1439	Prior Authorization is required.
Injection, ferumoxytol, for treatment of iron deficiency anemia, 1 mg (**non-esrd use**)	Q0138	Prior Authorization is required.
Injection, filgrastim (g-csf), excludes biosimilars, 1 microgram	J1442	Prior Authorization is required.
Injection, fondaparinux sodium, 0.5 mg	J1652	Prior Authorization is required.
Injection, fosnetupitant 235 mg and palonosetron 0.25 mg	J1454	Prior Authorization is required.
Injection, galsulfase, 1 mg	J1458	Prior Authorization is required.

Injection, golimumab, 1 mg, for intravenous use	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-articular injection, per dose	J7326	Prior Authorization is required.
Hyaluronan or derivative, gelsyn-3, for intra-articular injection, 0.1 mg	J7328	Prior Authorization is required.
Hyaluronan or derivitive, genvisc 850, for intra-articular injection, 1 mg	J7320	Prior Authorization is required.
Hyaluronan or derivative, hyalgan or supartz, for intra-articular injection, per dose	J7321	Prior Authorization is required.
Hyaluronan or derivative, monovisc, for intra-articular injection, per dose	J7327	Prior Authorization is required.
Hyaluronan or derivative, orthovisc, for intra-articular injection, per dose	J7324	Prior Authorization is required.
Injection, hydroxyprogesterone caproate, (makena), 10 mg	J1726	Prior Authorization is required.
Hyaluronan or derivative, synvisc or synvisc-one, for intra-articular injection, 1 mg	J7325	Prior Authorization is required.
Injection, idursulfase, 1 mg	J1743	Prior Authorization is required.
Injection, imiglucerase, 10 units	J1786	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), non-lyophilized, (e.g., liquid), 500 mg	J1566	Prior Authorization is required.
Injection, immune globulin, (gammagard liquid), non-lyophilized, (e.g., liquid), 500 mg	J1569	Prior Authorization is required.
Injection, immune globulin, (gamunex-c/gammaked), non-lyophilized (e.g., liquid), 500 mg	J1561	Prior Authorization is required.
Injection, immune globulin, (gammaplex), intravenous, non-lyophilized (e.g., liquid), 500 mg	J1557	Prior Authorization is required.
Injection, immune globulin (hizentra), 100 mg	J1559	Prior Authorization is required.
Injection, immune globulin, (octagam), intravenous, non-lyophilized (e.g., liquid), 500 mg	J1568	Prior Authorization is required.
Injection, immune globulin, intravenous, non-lyophilized (e.g., liquid), not otherwise specified, 500 mg	J1554	Prior Authorization is required.
Injection, immune globulin, intravenous, non-lyophilized (e.g., liquid), not otherwise specified, 500 mg	J1599	Prior Authorization is required.
Injection, immune globulin (privigen), intravenous, non-lyophilized (e.g., liquid), 500 mg	J1459	Prior Authorization is required.
Injection, immune globulin/hyaluronidase, (hyqvia), 100 mg immune globulin	J1575	Prior Authorization is required.
Injection, incobotulinumtoxin a, 1 unit	J0588	Prior Authorization is required.
Injection, inebilizumab-cdon, 1 mg	J1823	Prior Authorization is required.
Injection, infliximab, excludes biosimilar, 10 mg	J1745	Prior Authorization is required.
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)	J0593	Prior Authorization is required.
Injection, laronidase, 0.1 mg	J1931	Prior Authorization is required.
Leuprolide acetate (for depot suspension), 7.5 mg	J9217	Prior Authorization is required.
Injection, leuprolide acetate (for depot suspension), per 3.75 mg	J1950	Prior Authorization is required.
Injection, luspatercept-aamt, 0.25 mg	J0896	Prior Authorization is required.
Injection, mepolizumab, 1 mg	J2182	Prior Authorization is required.
Injection, methylnaltrexone, 0.1 mg	J2212	Prior Authorization is required.
Injection, natalizumab, 1 mg	J2323	Prior Authorization is required.
Injection, nusinersen, 0.1 mg	J2326	Prior Authorization is required.
Injection, ocrelizumab, 1 mg	J2350	Prior Authorization is required.
Injection, omalizumab, 5 mg	J2357	Prior Authorization is required.
Injection, onabotulinumtoxina, 1 unit	J0585	Prior Authorization is required.
Injection, patisiran, 0.1 mg	J0222	Prior Authorization is required.
Injection, pegaptanib sodium, 0.3 mg	J2503	Prior Authorization is required.
NOC drugs, other than inhalation drugs, administered through DME	J7799	The following drugs and corresponding NDC codes require prior authorization: Empaveli (73606001001)
Injection, pegfilgrastim, excludes biosimilar, 0.5 mg	J2506	Prior Authorization is required.
Injection, pegloticase, 1 mg	J2507	Prior Authorization is required.
Plasminogen, human-tvmh (Ryplazim)	J2998	Prior Authorization is required.
Injection, ranibizumab, 0.1 mg	J2778	Prior Authorization is required.
Injection, ravulizumab-cwvz, 10 mg	J1303	Prior Authorization is required.
Injection, reslizumab, 1 mg	J2786	Prior Authorization is required.
Injection, rimabotulinumtoxinb, 100 units	J0587	Prior Authorization is required.
Injection, rituximab, 10 mg	J9312	Prior Authorization is required.
Injection, romiplostim, 10 micrograms	J2796	Prior Authorization is required.
Injection, sebelipase alfa, 1 mg	J2840	Prior Authorization is required.
Unclassified drugs	J3490	The following drugs and corresponding NDC codes require prior authorization: Tegsedi, Nulibry, Uptravi (66215060206, 66215060214, 66215060406, 66215060606, 66215060806, 66215061006, 66215601206, 66215061406, 66215061606, 66215062820, 66215071801, 73129000101, 73129000199, 72126000701)
Injection, taliglucerase alfa, 10 units	J3060	Prior Authorization is required.
Injection, teprotumumab-trbw, 10 mg	J3241	Prior Authorization is required.
Injection, testosterone cypionate, 1 mg	J1071	Prior Authorization is required.
Testosterone pellet, 75 mg	S0189	Prior Authorization is required.
Injection, tocilizumab, 1 mg	J3262	Prior Authorization is required.
Injection, trastuzumab, excludes biosimilar, 10 mg	J9355	Prior Authorization is required.
Injection, treprostinil, 1 mg	J3285	Prior Authorization is required.
Treprostinil, inhalation solution, fda-approved final product, non-compounded, administered through dme, unit dose form, 1.74 mg	J7686	Prior Authorization is required.
Ustekinumab, for **subcutaneous** injection, 1 mg	J3357	Prior Authorization is required.

Ustekinumab, for **intravenous** injection, 1 mg	J3358	Prior Authorization is required.
Injection, vedolizumab, 1 mg	J3380	Prior Authorization is required.
Injection, velaglucerase alfa, 100 units	J3385	Prior Authorization is required.
Injection, verteporfin, 0.1 mg	J3396	Prior Authorization is required.
Injection, vestronidase alfa-vjbk, 1 mg	J3397	Prior Authorization is required.
Injection, von willebrand factor (recombinant), (vonvendi), 1 i.u. vwf:rco	J7179	Prior Authorization is required.
Injection, voretigene neparvovec-rzyl, 1 billion vector genomes	J3398	Prior Authorization is required.
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 15 minutes	S5150	Prior authorization is required. For additional information please refer to Respite Care-Pediatric, RP-1135.
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	S9125	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, per 15 minutes*	S5130	Prior authorization is required. For additional information please refer to Self-Directed Attendant Care-Non LTSS age 21 and Younger, RP-1133.
Diapers, Pads, and Supplies	**Codes**	**Prior Authorization Requirement**
Perianal fecal collection pouch with adhesive, each	A4330	Prior authorization is required if more than 8 units are billed per day.
Enema bag with tubing, reusable	A4458	Prior authorization is required if more than 8 units are billed per day.
Manual pump-operated enema system, includes balloon, catheter and all accessories, reusable, any type	A4459	Prior authorization is required if more than 8 units are billed per day.
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, brief/diaper, small, each	T4521	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, brief/diaper, medium, each	T4522	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, brief/diaper, large, each	T4523	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, 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, protective underwear/pull-on, small size, each	T4525	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, protective underwear/pull-on, medium size, each	T4526	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, protective underwear/pull-on, large size, each	T4527	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, protective underwear/pull-on, extra large size, each	T4528	Prior authorization is required if more than 8 units are billed per day. Not a covered service for members under 4.
Pediatric sized disposable incontinence product, brief/diaper, small/medium size, each	T4529	Prior authorization is required if more than 8 units are billed per day. 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. Not a covered service for members under 4.
Pediatric sized disposable incontinence product, protective underwear/pull-on, small/medium size, each	T4531	Prior authorization is required if more than 8 units are billed per day. Not a covered service for members under 4.
Pediatric sized disposable incontinence product, protective underwear/pull-on, large size, each	T4532	Prior authorization is required if more than 8 units are billed per day. Not a covered service for members under 4.
Youth sized disposable incontinence product, brief/diaper, each	T4533	Prior authorization is required if more than 8 units are billed per day. 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. Not a covered service for members under 4.
Disposable liner/shield/guard/pad/undergarment, for incontinence, each	T4535	Prior authorization is required if more than 8 units are billed per day.
Incontinence product, disposable underpad, large, each	T4541	Prior authorization is required if more than 8 units are billed per day.
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, protective brief/diaper, above extra large, each	T4543	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, protective underwear/pull-on, above extra large, each	T4544	Prior authorization is required if more than 8 units are billed per day. Not a covered service for members under 4.
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)	01999	Prior authorization is required.
Unlisted procedure, excision pressure ulcer	15999	Prior authorization is required.
Unlisted procedure: Skin, mucous membrane, and subcutaneous tissue	17999	Prior authorization is required.
Unlisted procedure: Breast	19499	Prior authorization is required.
Unlisted procedure, musculoskeletal system, general	20999	Prior authorization is required.
Unlisted maxillofacial prosthetic procedure	21089	Prior authorization is required.
Unlisted craniofacial and maxillofacial procedure	21299	Prior authorization is required.
Musculoskeletal procedure: Head	21499	Prior authorization is required.
Procedure: Neck or thorax	21899	Prior authorization is required.
Unlisted procedure: Spine	22899	Prior authorization is required.
Unlisted procedure, shoulder	23929	Prior authorization is required.
Unlisted procedure, humerus or elbow	24999	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	27299	Prior authorization is required.
Procedure: Knee	27599	Prior authorization is required.
Unlisted procedure, leg or ankle	27899	Prior authorization is required.
Unlisted Casting/Strapping	29799	Prior authorization is required.
Arthroscopy general joint procedure	29999	Prior authorization is required.
Unlisted procedure: Nose	30999	Prior authorization is required.
Unlisted procedure, accessory sinuses	31299	Prior authorization is required.
Unlisted procedure: Larynx	31599	Prior authorization is required.

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 system	38589	Prior authorization is required.
Procedure: Hemic or lymphatic system	38999	Prior authorization is required.
Unlisted procedure, mediastinum	39499	Prior authorization is required.
Unlisted procedure, diaphragm	39599	Prior authorization is required.
Procedure: Lips	40799	Prior authorization is required.
Unlisted procedure, vestibule of mouth	40899	Prior authorization is required.
Unlisted procedure, tongue, floor of mouth	41599	Prior authorization is required.
Procedure: Dentoalveolar structure	41899	Prior authorization is required.
Unlisted procedure: Palate, uvula	42299	Prior authorization is required.
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, esophagus	43289	Prior authorization is required.
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 rectum)	44238	Prior authorization is required.
Procedure: Intestine	44799	Prior authorization is required.
Unlisted procedure, Meckel's diverticulum and the mesentery	44899	Prior authorization is required.
Unlisted laparoscopy procedure, appendix	44979	Prior authorization is required.
Unlisted procedure, colon	45399	Prior authorization is required.
Unlisted laparoscopy procedure, rectum	45499	Prior authorization is required.
Unlisted procedure, rectum	45999	Prior authorization is required.
Unlisted procedure, anus	46999	Prior authorization is required.
Laparoscopy procedure: Liver	47379	Prior authorization is required.
Unlisted procedure, liver	47399	Prior authorization is required.
Unlisted laparoscopy procedure, biliary tract	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, peritoneum, omentum	49329	Prior authorization is required.
Laparoscopic procedure: Hernioplasty, herniography, herniotomy	49659	Prior authorization is required.
Procedure: Abdomen, peritoneum, and omentum	49999	Prior authorization is required.
Unlisted laparoscopy procedure, renal	50549	Prior authorization is required.
Unlisted laparoscopy procedure, ureter	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.
Laparoscopy procedure: Spermatic cord	55559	Prior authorization is required.
Procedure: Male genital	55899	Prior authorization is required.
Laparoscopy procedure: Uterus	58578	Prior authorization is required.
Laparoscopy procedure: Uterus	58579	Prior authorization is required.
Laparoscopy procedure: Ovary	58679	Prior authorization is required.
Unlisted procedure: Female genital system non-obstetrical	58999	Prior authorization is required.
Unlisted fetal invasive procedure, including ultrasound guidance, when performed	59897	Prior authorization is required.
Unlisted laparoscopy procedure, maternity care and delivery	59898	Prior authorization is required.
Unlisted procedure, maternity care and delivery	59899	Prior authorization is required.
Unlisted laparoscopy procedure, endocrine system	60659	Prior authorization is required.
Unlisted procedure, endocrine system	60699	Prior authorization is required.
Unlisted Procedure: Nervous system	64999	Prior authorization is required.
Unlisted procedure, anterior segment of eye	66999	Prior authorization is required.
Unlisted procedure, posterior segment	67299	Prior authorization is required.
Unlisted procedure, extraocular muscle	67399	Prior authorization is required.
Unlisted procedure, orbit	67599	Prior authorization is required.
Unlisted procedure: Eyelid	67999	Prior authorization is required.
Procedure: Conjunctiva (eye)	68399	Prior authorization is required.
Procedure: External ear	69399	Prior authorization is required.
Unlisted procedure, middle ear	69799	Prior authorization is required.
Unlisted procedure, inner ear	69949	Prior authorization is required.
Unlisted procedure, temporal bone, middle fossa approach	69979	Prior authorization is required.
Unlisted fluoroscopic procedure (eg, diagnostic, interventional)	76496	Prior authorization is required.
Unlisted computed tomography procedure (eg, diagnostic, interventional)	76497	Prior authorization is required.
Unlisted magnetic resonance procedure (eg, diagnostic, interventional)	76498	Prior authorization is required.
Unlisted diagnostic radiographic procedure	76499	Prior authorization is required.
Unlisted ultrasound procedure (eg, diagnostic, interventional)	76999	Prior authorization is required.
Unlisted procedure, therapeutic radiology clinical treatment planning	77299	Prior authorization is required.
Unlisted procedure, medical radiation physics, dosimetry and treatment devices, and special services	77399	Prior authorization is required.
Unlisted procedure, therapeutic radiology treatment management	77499	Prior authorization is required.
Unlisted procedure, clinical brachytherapy	77799	Prior authorization is required.
Unlisted endocrine procedure, diagnostic nuclear medicine	78099	Prior authorization is required.
Unlisted hematopoietic, reticuloendothelial and lymphatic procedure, diagnostic nuclear medicine	78199	Prior authorization is required.
Unlisted gastrointestinal procedure, diagnostic nuclear medicine	78299	Prior authorization is required.
Unlisted musculoskeletal procedure, diagnostic nuclear medicine	78399	Prior authorization is required.
Unlisted cardiovascular procedure, diagnostic nuclear medicine	78499	Prior authorization is required.

Unlisted respiratory procedure, diagnostic nuclear medicine	78599	Prior authorization is required.
Unlisted nervous system procedure, diagnostic nuclear medicine	78699	Prior authorization is required.
Unlisted genitourinary procedure, diagnostic nuclear medicine	78799	Prior authorization is required.
Unlisted miscellaneous procedure, diagnostic nuclear medicine	78999	Prior authorization is required.
Radiophamaceutical Therapy	79999	Prior authorization is required.
Unlisted procedure: Urinalysis	81099	Prior authorization is required.
Unlisted molecular pathology procedure	81479	Prior authorization is required.
Unlisted multianalyte assay with algotithmic analysis procedure	81599	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) observation; not otherwise specified	87899	Prior authorization is required.
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	88749	Prior authorization is required.
Unlisted pathology	89240	Prior authorization is required.
Reproductive laboratory procedure	89398	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.
Diagnostic procedure	91299	Prior authorization is required.
Unlisted ophthalmological service or procedure	92499	Prior authorization is required.
Unlisted otorhinolaryngological service or procedure	92700	Prior authorization is required.
Unlisted cardiovascular service or procedure	93799	Prior authorization is required.
Noninvasive vascular procedure	93998	Prior authorization is required.
Pulmonary service	94799	Prior authorization is required.
Allergy immunology	95199	Prior authorization is required.
Unlisted neurological or neuromuscular diagnostic procedure	95999	Prior authorization is required.
Unlisted injectable/therapeutic	96379	Prior authorization is required.
Unlisted chemotherapeutic injectable procedure	96549	Prior authorization is required.
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.
Unlisted special service, procedure, or report	99199	Prior authorization is required.
Evaluation and management service	99499	Prior authorization is required.
Unlisted home visit	99600	Prior authorization is required.
Mental health services, not otherwise specified	H0046	Prior authorization is required.
Alcohol and/or other drug abuse services, not otherwise specified	H0047	Prior authorization is required.
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	Q0181	Prior authorization is required.
Skin substitute, not otherwise specified	Q4100	Prior authorization is required.
Hospice or home health care provided in place not otherwise specified (NOS)	Q5009	Prior authorization is required.
DME Not Otherwise Classified Codes	**Codes**	**Prior Authorization Requirement**
Skin substitute, fda cleared as a device, not otherwise specified	A4100	Prior authorization is required for billed charges greater than $500.
Incontinence supply; miscellaneous	A4335	Prior authorization is required for billed charges greater than $500.
Ostomy supply; miscellaneous	A4421	Prior authorization is required for billed charges greater than $500.
Surgical supply; miscellaneous	A4649	Prior authorization is required for billed charges greater than $500.
Miscellaneous dialysis supplies, not otherwise specified	A4913	Prior authorization is required for billed charges greater than $500.
For diabetics only, not otherwise specified modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe, per shoe	A5507	Prior authorization is required for billed charges greater than $500.
Wound filler, gel/paste, per fluid ounce, not otherwise specified	A6261	Prior authorization is required for billed charges greater than $500.
Wound filler, dry form, per gram, not otherwise specified	A6262	Prior authorization is required for billed charges greater than $500.
Compression burn garment, not otherwise classified	A6512	Prior authorization is required for billed charges greater than $500.
Gradient compression stocking/sleeve, not otherwise specified	A6549	Prior authorization is required for billed charges greater than $500.
Single vitamin/mineral/trace element, oral, per dose, not otherwise specified	A9152	Prior authorization is required for billed charges greater than $500.
Multiple vitamins, with or without minerals and trace elements, oral, per dose, not otherwise specified	A9153	Prior authorization is required for billed charges greater than $500.
Monitoring feature/device, stand-alone or integrated, any type, includes all accessories, components and electronics, not otherwise classified	A9279	Prior authorization is required for billed charges greater than $500.
Alert or alarm device, not otherwise classified	A9280	Prior authorization is required for billed charges greater than $500.
Miscellaneous dme supply, accessory, and/or service component of another hcpcs code	A9900	Prior authorization is required for billed charges greater than $500.

Miscellaneous dme supply or accessory, not otherwise specified	A9999	Prior authorization is required for billed charges greater than $500.
Parenteral nutrition solution, not otherwise specified, 10 grams lipids	B4185	Prior authorization is required for billed charges greater than $500.
Noc for enteral supplies	B9998	Prior authorization is required for billed charges greater than $500.
Noc for parenteral supplies	B9999	Prior authorization is required for billed charges greater than $500.
Implantable/insertable device, not otherwise classified	C1889	Prior authorization is required for billed charges greater than $500.
Topical oxygen delivery system, not otherwise specified, includes all supplies and accessories	E0446	Prior authorization is required for billed charges greater than $500.
Patient lift, bathroom or toilet, not otherwise classified	E0625	Prior authorization is required for billed charges greater than $500.
Intermittent limb compression device (includes all accessories), not otherwise specified	E0676	Prior authorization is required for billed charges greater than $500.
Electrical stimulation or electromagnetic wound treatment device, not otherwise classified	E0769	Prior authorization is required for billed charges greater than $500.
Functional electrical stimulator, transcutaneous stimulation of nerve and/or muscle groups, any type, complete system, not otherwise specified	E0770	Prior authorization is required for billed charges greater than $500.
Wheelchair, pediatric size, not otherwise specified	E1229	Prior authorization is required for billed charges greater than $500.
Power wheelchair, pediatric size, not otherwise specified	E1239	Prior authorization is required for billed charges greater than $500.
Durable medical equipment, miscellaneous	E1399	Prior authorization is required for billed charges greater than $500.
Dialysis equipment, not otherwise specified	E1699	Prior authorization is required for billed charges greater than $500.
Accessory for speech generating device, not otherwise classified	E2599	Prior authorization is required for billed charges greater than $500.
Wheelchair component or accessory, not otherwise specified	K0108	Prior authorization is required for billed charges greater than $500.
Power operated vehicle, not otherwise classified	K0812	Prior authorization is required for billed charges greater than $500.
Power wheelchair, not otherwise classified	K0898	Prior authorization is required for billed charges greater than $500.
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 specified	L2999	Prior authorization is required for billed charges greater than $500.
Orthopedic shoe, modification, addition or transfer, not otherwise specified	L3649	Prior authorization is required for billed charges greater than $500.
Upper limb orthosis, not otherwise specified	L3999	Prior authorization is required for billed charges greater than $500.
Lower extremity prosthesis, not otherwise specified	L5999	Prior authorization is required for billed charges greater than $500.
Upper extremity prosthesis, not otherwise specified	L7499	Prior authorization is required for billed charges greater than $500.
Breast prosthesis, not otherwise specified	L8039	Prior authorization is required for billed charges greater than $500.
Unspecified maxillofacial prosthesis, by report, provided by a non-physician	L8048	Prior authorization is required for billed charges greater than $500.
Unlisted procedure for miscellaneous prosthetic services	L8499	Prior authorization is required for billed charges greater than $500.
Miscellaneous external component, supply or accessory for use with the argus ii retinal prosthesis system	L8608	Prior authorization is required for billed charges greater than $500.
Miscellaneous component, supply or accessory for use with total artificial heart system	L8698	Prior authorization is required for billed charges greater than $500.
Prosthetic implant, not otherwise specified	L8699	Prior authorization is required for billed charges greater than $500.
Miscellaneous supply or accessory for use with an external ventricular assist device	Q0507	Prior authorization is required for billed charges greater than $500.
Miscellaneous supply or accessory for use with an implanted ventricular assist device	Q0508	Prior authorization is required for billed charges greater than $500.
Miscellaneous supply or accessory for use with any implanted ventricular assist device for which payment was not made under medicare part a	Q0509	Prior authorization is required for billed charges greater than $500.
Cast supplies, for unlisted types and materials of casts	Q4050	Prior authorization is required for billed charges greater than $500.
Splint supplies, miscellaneous (includes thermoplastics, strapping, fasteners, padding and other supplies)	Q4051	Prior authorization is required for billed charges greater than $500.
Skin substitute, not otherwise specified	Q4100	Prior authorization is required for billed charges greater than $500.
Tracheostomy supply, not otherwise classified	S8189	Prior authorization is required for billed charges greater than $500.
Infection control supplies, not otherwise specified	S8301	Prior authorization is required for billed charges greater than $500.
Specialized supply, not otherwise specified, waiver	T2028	Prior authorization is required for billed charges greater than $500.
Specialized medical equipment, not otherwise specified, waiver	T2029	Prior authorization is required for billed charges greater than $500.
Supply, not otherwise specified	T5999	Prior authorization is required for billed charges greater than $500.
Dispensing fee, unspecified hearing aid	V5090	Prior authorization is required for billed charges greater than $500.
Hearing aid or assistive listening device/supplies/accessories, not otherwise specified	V5267	Prior authorization is required for billed charges greater than $500.
Assistive listening device, not otherwise specified	V5274	Prior authorization is required for billed charges greater than $500.
Assistive listening device, personal fm/dm receiver, not otherwise specified	V5287	Prior authorization is required for billed charges greater than $500.
Hearing aid, not otherwise classified	V5298	Prior authorization is required for billed charges greater than $500.
Hearing service, miscellaneous	V5299	Prior authorization is required for billed charges greater than $500.
Repair orthotic device	L4210	Prior authorization is required for billed charges greater than $500.

Prosthetic repair	L7510	Prior authorization is required for billed charges greater than $500.
Site of Care	**Codes**	**Prior Authorization Requirement**
Policy Forthcoming		
Molecular Tumor Markers for Non-Small Lung Cancer	**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 immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, per specimen, each single antibody stain procedure; manual	88360	Prior authorization is required. For additional information please reference Molecular Tumor Markers for Non-Small Lung Cancer, MP-DE-1028
Morphometric analysis, tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, 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.
Evaluation of speech fluency (eg, stuttering, 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 programming	92601	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; subsequent reprogramming	92602	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; 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 device, replacement	L8618	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 and controller, integrated system, replacement	L8619	Prior authorization is required for billed charges greater than $500. Please refer to Cochlear Implants, MP-DE-1145 for medical necessity criteria.
Zinc air battery for use with cochlear implant device and auditory osseointegrated sound processors, replacement, each	L8621	Prior authorization is required for billed charges greater than $500. Please refer to Cochlear Implants, MP-DE-1145 for medical necessity criteria.
Alkaline battery for use with cochlear implant device, any size, replacement, each	L8622	Prior authorization is required for billed charges greater than $500. Please refer to Cochlear Implants, MP-DE-1145 for medical necessity criteria.
Lithium ion battery for use with cochlear implant device speech processor, other than ear level, replacement, each	L8623	Prior authorization is required for billed charges greater than $500. Please refer to Cochlear Implants, MP-DE-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 performed (separate procedure)	43235	Prior authorization is required. Please refer to Bariatric Surgery, MP-DE-1004 for additional requirements.
Esophagogastroduodenoscopy, flexible, transoral; with directed submucosal injection(s), any substance	43236	Prior authorization is required. Please refer to Bariatric Surgery, MP-DE-1004 for additional requirements.
Esophagogastroduodenoscopy, flexible, transoral; with endoscopic ultrasound examination limited to the esophagus, stomach or duodenum, and adjacent structures	43237	Prior authorization is required. Please refer to Bariatric Surgery, MP-DE-1004 for additional requirements.
Esophagogastroduodenoscopy, flexible, transoral; with injection sclerosis of esophageal/gastric varices	43243	Prior authorization is required. Please refer to Bariatric Surgery, MP-DE-1004 for additional requirements.
Esophagogastroduodenoscopy, flexible, transoral; with band ligation of esophageal/gastric varices	43244	Prior authorization is required. Please refer to Bariatric Surgery, MP-DE-1004 for additional requirements.
Esophagogastroduodenoscopy, flexible, transoral; with dilation of gastric/duodenal stricture(s) (eg, balloon, bougie)	43245	Prior authorization is required. Please refer to Bariatric Surgery, MP-DE-1004 for additional requirements.

Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-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)	43253	Prior authorization is required. Please refer to Bariatric Surgery, MP-DE-1004 for additional requirements.
Gastrectomy, partial, distal; with gastroduodenostomy	43631	Prior authorization is required. Please refer to Bariatric Surgery, MP-DE-1004 for additional requirements.
Gastrectomy, partial, distal; with gastrojejunostomy	43632	Prior authorization is required. Please refer to Bariatric Surgery, MP-DE-1004 for additional requirements.
Gastrectomy, partial, distal; with Roux-en-Y reconstruction	43633	Prior authorization is required. Please refer to Bariatric Surgery, MP-DE-1004 for additional requirements.
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-Y gastroenterostomy (roux limb 150 cm or less)	43644	Prior authorization is required. Please refer to Bariatric Surgery, MP-DE-1004 for additional requirements.
Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and small intestine reconstruction to limit absorption	43645	Prior authorization is required. Please refer to Bariatric Surgery, MP-DE-1004 for additional requirements.
Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric restrictive device (eg, gastric band and subcutaneous port components)	43770	Prior authorization is required. Please refer to Bariatric Surgery, MP-DE-1004 for additional requirements.
Laparoscopy, surgical, gastric restrictive procedure; revision of adjustable gastric restrictive device component only	43771	Prior authorization is required. Please refer to Bariatric Surgery, MP-DE-1004 for additional requirements.
Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device component only	43772	Prior authorization is required. Please refer to Bariatric Surgery, MP-DE-1004 for additional requirements.
Laparoscopy, surgical, gastric restrictive procedure; removal and replacement of adjustable gastric restrictive device component only	43773	Prior authorization is required. Please refer to Bariatric Surgery, MP-DE-1004 for additional requirements.
Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device and subcutaneous port components	43774	Prior authorization is required. Please refer to Bariatric Surgery, MP-DE-1004 for additional requirements.
Laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy (ie, sleeve gastrectomy)	43775	Prior authorization is required. Please refer to Bariatric Surgery, MP-DE-1004 for additional requirements.
Gastric restrictive procedure, without gastric bypass, for morbid obesity; vertical-banded gastroplasty	43842	Prior authorization is required. Please refer to Bariatric Surgery, MP-DE-1004 for additional requirements.
Gastric restrictive procedure, without gastric bypass, for morbid obesity; other than vertical-banded gastroplasty	43843	Prior authorization is required. Please refer to Bariatric Surgery, MP-DE-1004 for additional requirements.
Gastric restrictive procedure with partial gastrectomy, pylorus-preserving duodenoileostomy and ileoileostomy (50 to 100 cm common channel) to limit absorption (biliopancreatic diversion with duodenal switch)	43845	Prior authorization is required. Please refer to Bariatric Surgery, MP-DE-1004 for additional requirements.
Gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb (150 cm or less) Roux-en-Y gastroenterostomy	43846	Prior authorization is required. Please refer to Bariatric Surgery, MP-DE-1004 for additional requirements.
Gastric restrictive procedure, with gastric bypass for morbid obesity; with small intestine reconstruction to limit absorption	43847	Prior authorization is required. Please refer to Bariatric Surgery, MP-DE-1004 for additional requirements.
Revision, open, of gastric restrictive procedure for morbid obesity, other than adjustable gastric restrictive device (separate procedure)	43848	Prior authorization is required. Please refer to Bariatric Surgery, MP-DE-1004 for additional requirements.
Revision of gastrojejunal anastomosis (gastrojejunostomy) with reconstruction, with or without partial gastrectomy or intestine resection; without vagotomy	43860	Prior authorization is required. Please refer to Bariatric Surgery, MP-DE-1004 for additional requirements.
Revision of gastrojejunal anastomosis (gastrojejunostomy) with reconstruction, with or without partial gastrectomy or intestine resection; with vagotomy	43865	Prior authorization is required. Please refer to Bariatric Surgery, MP-DE-1004 for additional requirements.
Gastric restrictive procedure, open; revision of subcutaneous port component only	43886	Prior authorization is required. Please refer to Bariatric Surgery, MP-DE-1004 for additional requirements.
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 and replacement of subcutaneous port component only	43888	Prior authorization is required. Please refer to Bariatric Surgery, MP-DE-1004 for additional requirements.
Adjustment of gastric band diameter via subcutaneous port by injection or aspiration of saline	S2083	Prior authorization is required. Please refer to Bariatric Surgery, MP-DE-1004 for additional requirements.
Colorectal Screenings	**Codes**	**Prior Authorization Requirement**
Computed tomographic (CT) colonography, screening, including image postprocessing	74263	Prior Authorization is required for members under the age of 45. Please refer to Colorectal Cancer Screening, MP-DE-1007
Radiologic examination, colon, including scout abdominal radiograph(s) and delayed image(s), when performed; double-contrast (eg, high density barium and air) study, including glucagon, when administered	74280	Prior Authorization is required for members under the age of 45. Please refer to Colorectal Cancer Screening, MP-DE-1007
Oncology (colorectal) screening, quantitative real-time target and signal amplification of 10 DNA markers (KRAS mutations, promoter methylation of NDRG4 and BMP3) and fecal hemoglobin, utilizing stool, algorithm reported as a positive or negative result	81528	Prior Authorization is required for members under the age of 45. Please refer to Colorectal Cancer Screening, MP-DE-1007
Blood, occult, by peroxidase activity (eg, guaiac), qualitative; feces, consecutive collected specimens with single determination, for colorectal neoplasm screening (ie, patient was provided 3 cards or single triple card for consecutive collection)	82270	Prior Authorization is required for members under the age of 45. Please refer to Colorectal Cancer Screening, MP-DE-1007
Blood, occult, by peroxidase activity (eg, guaiac), qualitative, feces, 1-3 simultaneous determinations, performed for other than colorectal neoplasm screening	82272	Prior Authorization is required for members under the age of 45. Please refer to Colorectal Cancer Screening, MP-DE-1007
Blood, occult, by fecal hemoglobin determination by immunoassay, qualitative, feces, 1-3 simultaneous determinations	82274	Prior Authorization is required for members under the age of 45. Please refer to Colorectal Cancer Screening, MP-DE-1007
Cytopathology, smears, any other source; screening and interpretation	88160	Prior Authorization is required for members under the age of 45. Please refer to Colorectal Cancer Screening, MP-DE-1007
Colorectal cancer screening; flexible sigmoidoscopy	G0104	Prior Authorization is required for members under the age of 45. Please refer to Colorectal Cancer Screening, MP-DE-1007
Colorectal cancer screening; colonoscopy on individual at high risk	G0105	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 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 enema	G0120	Prior Authorization is required for members under the age of 45. Please refer to Colorectal Cancer Screening, MP-DE-1007
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, MP-DE-1007
olorectal cancer screening; barium enema	G0122	Prior Authorization is required for members under the age of 45. Please refer to Colorectal Cancer Screening, MP-DE-1007
Colorectal cancer screening; fecal occult blood test, immunoassay, one to three simultaneous determinations	G0328	Prior Authorization is required for members under the age of 45. Please refer to Colorectal Cancer Screening, MP-DE-1007
Pharmacogenomic Testing	**Codes**	**Prior Authorization Requirement**
DPYD (dihydropyrimidine dehydrogenase) (eg, 5-fluorouracil/5-FU and capecitabine drug metabolism), gene analysis, common variant(s) (eg, 2A, 4, 5, 6)	81232	Prior authorization is required. Please refer to Pharmacogenomic Testing, MP-DE-1002 for additional requirements.
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)	81230	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)	81231	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 variants (eg, 2, 3)	81335	Prior authorization is required. Please refer to Pharmacogenomic Testing, MP-DE-1002 for additional requirements.
G6PD (glucose-6-phosphate dehydrogenase) (eg, hemolytic anemia, jaundice), gene analysis; common variant(s) (eg, A, A-)	81247	Prior authorization is required. Please refer to Pharmacogenomic Testing, MP-DE-1002 for additional 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, estrogen receptor/progesterone receptor), quantitative or semiquantitative, per specimen, each single antibody stain procedure; manual	88360	Prior authorization is required. Please refer to Pharmacogenomic Testing, MP-DE-1002 for additional requirements.
Breast Reconstructive Surgery	**Codes**	**Prior Authorization Requirement**
Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.0 sq cm or less	11920	Prior authorization is required. Please refer to Breast Reconstructive Surgery, MP-DE-1027 for additional requirements.
Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.1 to 20.0 sq cm	11921	Prior authorization is required. Please refer to Breast Reconstructive Surgery, MP-DE-1027 for additional requirements.
Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; each additional 20.0 sq cm, or part thereof (List separately in addition to code for primary procedure)	11922	Prior authorization is required. Please refer to Breast Reconstructive Surgery, MP-DE-1027 for additional requirements.
Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy);	19301	Prior authorization is required. Please refer to Breast Reconstructive Surgery, MP-DE-1027 for additional requirements.
Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy); with axillary lymphadenectomy	19302	Prior authorization is required. Please refer to Breast Reconstructive Surgery, MP-DE-1027 for additional requirements.
Mastectomy, simple, complete	19303	Prior authorization is required. Please refer to Breast Reconstructive Surgery, MP-DE-1027 for additional requirements.
Mastectomy, radical, including pectoral muscles, axillary lymph nodes	19305	Prior authorization is required. Please refer to Breast Reconstructive Surgery, MP-DE-1027 for additional requirements.
Mastectomy, radical, including pectoral muscles, axillary and internal mammary lymph nodes (Urban type operation)	19306	Prior authorization is required. Please refer to Breast Reconstructive Surgery, MP-DE-1027 for additional requirements.
Mastectomy, modified radical, including axillary lymph nodes, with or without pectoralis minor muscle, but excluding pectoralis major muscle	19307	Prior authorization is required. Please refer to Breast Reconstructive Surgery, MP-DE-1027 for additional requirements.
Mastopexy	19316	Prior authorization is required. Please refer to Breast Reconstructive Surgery, MP-DE-1027 for additional requirements.
Breast reduction	19318	Prior authorization is required. Please refer to Breast Reconstructive Surgery, MP-DE-1027 for additional requirements.
Breast augmentation with implant	19325	Prior authorization is required. Please refer to Breast Reconstructive Surgery, MP-DE-1027 for additional requirements.
Removal of intact breast implant	19328	Prior authorization is required. Please refer to Breast Reconstructive Surgery, MP-DE-1027 for additional requirements.
Removal of ruptured breast implant, including implant contents (eg, saline, silicone gel)	19330	Prior authorization is required. Please refer to Breast Reconstructive Surgery, MP-DE-1027 for additional requirements.
Insertion of breast implant on same day of mastectomy (ie, immediate)	19340	Prior authorization is required. Please refer to Breast Reconstructive Surgery, MP-DE-1027 for additional requirements.
Insertion or replacement of breast implant on separate day from mastectomy	19342	Prior authorization is required. Please refer to Breast Reconstructive Surgery, MP-DE-1027 for additional requirements.
Nipple/areola reconstruction	19350	Prior authorization is required. Please refer to Breast Reconstructive Surgery, MP-DE-1027 for additional requirements.
Tissue expander placement in breast reconstruction, including subsequent expansion(s)	19357	Prior authorization is required. Please refer to Breast Reconstructive Surgery, MP-DE-1027 for additional requirements.
Breast reconstruction; with latissimus dorsi flap	19361	Prior authorization is required. Please refer to Breast Reconstructive Surgery, MP-DE-1027 for additional requirements.
Breast reconstruction; with free flap (eg, fTRAM, DIEP, SIEA, GAP flap)	19364	Prior authorization is required. Please refer to Breast Reconstructive Surgery, MP-DE-1027 for additional requirements.
Breast reconstruction; with single-pedicled transverse rectus abdominis myocutaneous (TRAM) flap	19367	Prior authorization is required. Please refer to Breast Reconstructive Surgery, MP-DE-1027 for additional requirements.

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, any type	L8000	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, with integrated breast prosthesis form, unilateral, any size, any type	L8001	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, 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 Surgery, MP-DE-1027 for additional requirements.
Breast prosthesis, silicone or equal, with integral adhesive	L8031	Prior authorization is required for billed charges greater than $500. Please refer to Breast Reconstructive Surgery, MP-DE-1027 for additional requirements.
Nipple prosthesis, prefabricated, reusable, any type, each	L8032	Prior authorization is required for billed charges greater than $500. Please refer to Breast Reconstructive Surgery, MP-DE-1027 for additional requirements.
Custom breast prosthesis, post mastectomy, molded to patient model	L8035	Prior authorization is required for billed charges greater than $500. Please refer to Breast Reconstructive Surgery, MP-DE-1027 for additional requirements.
Breast prosthesis, not otherwise specified	L8039	Prior authorization is required for billed charges greater than $500. Please refer to Breast Reconstructive Surgery, MP-DE-1027 for additional requirements.
BCR-BL1 Testing in Chronic Myeologenous Leukemia	**Codes**	**Prior Authorization Requirement**
ABL1 (ABL proto-oncogene 1, non-receptor tyrosine kinase) (eg, acquired imatinib tyrosine kinase inhibitor resistance), gene analysis, variants in the kinase domain	81170	Prior authorization is required. Please refer to BCR-BL1 Testing in Chronic Myeologenous Leukemia, MP-DE-1035 for additional requirements.
BCR/ABL1 (t(9;22)) (eg, chronic myelogenous leukemia) translocation analysis; major breakpoint, qualitative or quantitative	81206	Prior authorization is required. Please refer to BCR-BL1 Testing in Chronic Myeologenous Leukemia, MP-DE-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 neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), without use of intraoperative microelectrode recording; first array	61863	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 neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), without use of intraoperative microelectrode recording; each additional array (List separately in addition to primary procedure)	61864	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 neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), with use of intraoperative microelectrode recording; first array	61867	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 neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), with use of intraoperative microelectrode recording; each additional array (List separately in addition to primary procedure)	61868	Prior authorization is required. Please refer to Deep Brain Stimulation, MP-DE-1009 for additional requirements.
Revision or removal of intracranial neurostimulator electrodes	61880	Prior authorization is required. Please refer to Deep Brain Stimulation, MP-DE-1009 for additional requirements.
Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array	61885	Prior authorization is required. Please refer to Deep Brain Stimulation, MP-DE-1009 for additional requirements.
Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to 2 or more electrode arrays	61886	Prior authorization is required. Please refer to Deep Brain Stimulation, MP-DE-1009 for additional requirements.
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 written report, up to 30 days	95836	Prior authorization is required. Please refer to Deep Brain Stimulation, MP-DE-1009 for additional requirements.
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; initial hour of attendance by a physician or other qualified health care professional	95961	Prior authorization is required. Please refer to Deep Brain Stimulation, MP-DE-1009 for additional requirements.

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 [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	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, sacral 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 [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 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 [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	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 [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	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-to-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 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)	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.
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 recharging system for battery (external) for use with implantable neurostimulator, replacement only	L8695	Prior authorization is required for billed charges greater than $500. Please refer to Deep Brain Stimulation, MP-DE-1009 for additional requirements.
Whole Exome/Whole Genome Sequencing	**Codes**	**Prior Authorization Requirement**
Unlisted molecular pathology procedure	81479	Prior authorization is required. Please refer to Whole Exome/Whole Genome Sequencing, MP-DE-1012 for additional requirements.
Pain management, mRNA, gene expression profiling by RNA sequencing of 36 genes, whole blood, algorithm reported as predictive risk score	0290U	Prior authorization is required. Please refer to Whole Exome/Whole Genome Sequencing, MP-DE-1012 for additional requirements.
Kidney Transplant	**Codes**	**Prior Authorization Requirement**
Donor nephrectomy (including cold preservation); open, from living donor	50320	Prior authorization is required. Please refer to Kidney Transplant, MP-DE-1017 for additional requirements.
Recipient nephrectomy (separate procedure)	50340	Prior authorization is required. Please refer to Kidney Transplant, MP-DE-1017 for additional requirements.
Renal allotransplantation, implantation of graft; without recipient nephrectomy	50360	Prior authorization is required. Please refer to Kidney Transplant, MP-DE-1017 for additional requirements.
Renal allotransplantation, implantation of graft; with recipient nephrectomy	50365	Prior authorization is required. Please refer to Kidney Transplant, MP-DE-1017 for additional requirements.
Removal of transplanted renal allograft	50370	Prior authorization is required. Please refer to Kidney Transplant, MP-DE-1017 for additional requirements.
Renal autotransplantation, reimplantation of kidney	50380	Prior authorization is required. Please refer to Kidney Transplant, MP-DE-1017 for additional requirements.
Laparoscopy, surgical; donor nephrectomy (including cold preservation), from living donor	50547	Prior authorization is required. Please refer to Kidney Transplant, MP-DE-1017 for additional requirements.
Abdominoplasty and Panniculectomy	**Codes**	**Prior Authorization Requirement**
Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy	15830	Prior authorization is required. Please refer to Abdominoplasty and Panniculectomy, MP-DE-1003 for additional requirements.
Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (eg, abdominoplasty) (includes umbilical transposition and fascial plication) (List separately in addition to code for primary procedure)	15847	Prior authorization is required. Please refer to Abdominoplasty and Panniculectomy, MP-DE-1003 for additional requirements.
Aqueous Shunts and Stents for Glaucoma	**Codes**	**Prior Authorization Requirement**
Transluminal dilation of aqueous outflow canal; without retention of device or stent	66174	Prior authorization is required. Please refer to Aqueous Shunts and Stents for Glaucoma, MP-DE-1024 for additional requirements.
Insertion of anterior segment aqueous drainage device, without extraocular reservoir, external approach	66183	Prior authorization is required. Please refer to Aqueous Shunts and Stents for Glaucoma, MP-DE-1024 for additional requirements.
Transluminal dilation of aqueous outflow canal; with retention of device or stent	66175	Prior authorization is required. Please refer to Aqueous Shunts and Stents for Glaucoma, MP-DE-1024 for additional requirements.
Implantable Hormone Replacement Pellets	**Codes**	**Prior Authorization Requirement**
Subcutaneous hormone pellet implantation (implantation of estradiol and/or testosterone pellets beneath the skin)	11980	Prior authorization is required. Please refer to Implantable Hormone Replacement Pellets, MP-DE-1033 for additional requirements.
Cognitive Rehabilitation	**Codes**	**Prior Authorization Requirement**
Therapeutic interventions that focus on 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	97129	Prior authorization is required. Please refer to Cognitive Rehabilitation, MP-DE-1044 for additional requirements.
Therapeutic interventions that focus on 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)	97130	Prior authorization is required. Please refer to Cognitive Rehabilitation, MP-DE-1044 for additional requirements.
Psychiatric Care Defined	**Codes**	**Prior Authorization Requirement**
Electroconvulsive therapy (includes necessary monitoring)	90870	Prior authorization is required. Please refer to Psychiatric Care Defined, MP-DE-1046 for additional requirements.
Developmental test administration (including assessment of fine and/or gross motor, 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	96112	Prior authorization is required. Please refer to Psychiatric Care Defined, MP-DE-1046 for additional requirements.
Standardized cognitive performance testing (eg, Ross Information Processing 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	96125	Prior authorization is required. Please refer to Psychiatric Care Defined, MP-DE-1046 for additional requirements.
Psychological testing evaluation services by 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; first hour	96130	Prior authorization is required. Please refer to Psychiatric Care Defined, MP-DE-1046 for additional requirements.
Psychological testing evaluation services by 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)	96131	Prior authorization is required. Please refer to Psychiatric Care Defined, MP-DE-1046 for additional requirements.
Neuropsychological testing evaluation services by 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; first hour	96132	Prior authorization is required. Please refer to Psychiatric Care Defined, MP-DE-1046 for additional requirements.

Neuropsychological testing evaluation services by 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)	96133	Prior authorization is required. Please refer to Psychiatric Care Defined, MP-DE-1046 for additional requirements.
Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; first 30 minutes	96136	Prior authorization is required. Please refer to Psychiatric Care Defined, MP-DE-1046 for additional requirements.
Psychological or neuropsychological test administration and scoring by physician 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)	96137	Prior authorization is required. Please refer to Psychiatric Care Defined, MP-DE-1046 for additional requirements.
Psychological or neuropsychological test administration, with single automated, standardized instrument via electronic platform, with automated result only	96146	Prior authorization is required. Please refer to Psychiatric Care Defined, MP-DE-1046 for additional requirements.
Behavior identification assessment, administered by a physician or other qualified health care professional, each 15 minutes of 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	97151	Prior authorization is required. Please refer to Psychiatric Care Defined, MP-DE-1046 for additional requirements.
Small Bowel, Liver, and Multivisceral Transplantation	**Codes**	**Prior Authorization Requirement**
Donor enterectomy (including cold preservation), open; partial, from living donor	44133	Prior authorization is required. Please refer to Small Bowel, Liver, and Multivisceral Transplantation, MP-DE-1051 for additional requirements.
Intestinal allotransplantation; from cadaver donor	44135	Prior authorization is required. Please refer to Small Bowel, Liver, and Multivisceral Transplantation, MP-DE-1051 for additional requirements.
Intestinal allotransplantation; from living donor	44136	Prior authorization is required. Please refer to Small Bowel, Liver, and Multivisceral Transplantation, MP-DE-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 Cryosurgery of Primary or Metastatic Liver Tumors	**Codes**	**Prior Authorization Requirement**
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); radiofrequency	47380	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), percutaneous, radiofrequency	47382	Prior authorization is required. Please refer to Radiofrequency Ablation and Cryosurgery of Primary or 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), percutaneous, cryoablation	47383	Prior authorization is required. Please refer to Radiofrequency Ablation and Cryosurgery of Primary or Metastatic Liver Tumors, MP-DE-1052 for additional requirements.
Endovascular Procedures for Intracranial and Extracranial Cerebral Vascular Disease	**Codes**	**Prior Authorization Requirement**
Transcatheter placement of intravascular stent(s), cervical carotid artery, open or percutaneous, including angioplasty, when performed, and radiological supervision and interpretation; with distal embolic protection	37215	Prior authorization is required. Please refer to Endovascular Procedures for Intracranial and Extracranial Cerebral Vascular Disease, MP-DE-1056 for additional requirements.
Transcatheter placement of intravascular stent(s), cervical carotid artery, open or percutaneous, including angioplasty, when performed, and radiological supervision and interpretation; without distal embolic protection	37216	Prior authorization is required. Please refer to Endovascular Procedures for Intracranial and Extracranial Cerebral Vascular Disease, MP-DE-1056 for additional requirements.
Transcatheter placement of intravascular stent(s), intrathoracic common carotid artery or innominate artery, open or percutaneous antegrade approach, including angioplasty, when performed, and radiological supervision and interpretation	37218	Prior authorization is required. Please refer to Endovascular Procedures for Intracranial and Extracranial Cerebral Vascular Disease, MP-DE-1056 for additional requirements.
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 cerebellar artery) (List separately in addition to code for primary procedure)	36228	Prior authorization is required. Please refer to Endovascular Procedures for Intracranial and Extracranial Cerebral Vascular Disease, MP-DE-1056 for additional requirements.
Surgical Treatment of Varicose Veins	**Codes**	**Prior Authorization Requirement**
Endovenous catheter directed chemical ablation with balloon isolation of incompetent extremity vein, open or percutaneous, including all vascular access, catheter manipulation, diagnostic imaging, imaging guidance and monitoring	0524T	Prior authorization is required. Please refer to Surgical Treatment of Varicose Veins, MP-DE-1100 for additional requirements.
Destruction of cutaneous vascular proliferative lesions (eg, laser technique); less than 10 sq cm	17106	Prior authorization is required. Please refer to Surgical Treatment of Varicose Veins, MP-DE-1100 for additional requirements.
Destruction of cutaneous vascular proliferative lesions (eg, laser technique); 10.0 to 50.0 sq cm	17107	Prior authorization is required. Please refer to Surgical Treatment of Varicose Veins, MP-DE-1100 for additional requirements.
Destruction of cutaneous vascular proliferative lesions (eg, laser technique); over 50.0 sq cm	17108	Prior authorization is required. Please refer to Surgical Treatment of Varicose Veins, MP-DE-1100 for additional requirements.
Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance and monitoring; single incompetent extremity truncal vein (eg, great saphenous vein, accessory saphenous vein)	36465	Prior authorization is required. Please refer to Surgical Treatment of Varicose Veins, MP-DE-1100 for additional requirements.

Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance and monitoring; multiple incompetent truncal veins (eg, great saphenous vein, accessory saphenous vein), same leg	36466	Prior authorization is required. Please refer to Surgical Treatment of Varicose Veins, MP-DE-1100 for additional requirements.
Injection(s) of sclerosant for spider veins (telangiectasia), limb or trunk	36468	Prior authorization is required. Please refer to Surgical Treatment of Varicose Veins, MP-DE-1100 for additional requirements.
Injection of sclerosant; single incompetent vein (other than telangiectasia)	36470	Prior authorization is required. Please refer to Surgical Treatment of Varicose Veins, MP-DE-1100 for additional requirements.
Injection of sclerosant; multiple incompetent 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 vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; first vein treated	36473	Prior authorization is required. Please refer to Surgical Treatment of Varicose Veins, MP-DE-1100 for additional requirements.
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)	36474	Prior authorization is required. Please refer to Surgical Treatment of Varicose Veins, MP-DE-1100 for additional requirements.
Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated	36475	Prior authorization is required. Please refer to Surgical Treatment of Varicose Veins, MP-DE-1100 for additional requirements.
Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)	36476	Prior authorization is required. Please refer to Surgical Treatment of Varicose Veins, MP-DE-1100 for additional requirements.
Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated	36478	Prior authorization is required. Please refer to Surgical Treatment of Varicose Veins, MP-DE-1100 for additional requirements.
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)	36479	Prior authorization is required. Please refer to Surgical Treatment of Varicose Veins, MP-DE-1100 for additional requirements.
Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; first vein treated	36482	Prior authorization is required. Please refer to Surgical Treatment of Varicose Veins, MP-DE-1100 for additional requirements.
Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)	36483	Prior authorization is required. Please refer to Surgical Treatment of Varicose Veins, MP-DE-1100 for additional requirements.
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 additional requirements.
Ligation and division of long saphenous vein at saphenofemoral junction, or distal interruptions	37700	Prior authorization is required. Please refer to Surgical Treatment of Varicose Veins, MP-DE-1100 for additional requirements.
Ligation, division, and stripping, short saphenous vein	37718	Prior authorization is required. Please refer to Surgical Treatment of Varicose Veins, MP-DE-1100 for additional requirements.
Ligation, division, and stripping, long (greater) saphenous veins from saphenofemoral junction to knee or below	37722	Prior authorization is required. Please refer to Surgical Treatment of Varicose Veins, MP-DE-1100 for additional requirements.
Ligation and division and complete stripping of long or short saphenous veins with radical excision of ulcer and skin graft and/or interruption of communicating veins of lower leg, with excision of deep fascia	37735	Prior authorization is required. Please refer to Surgical Treatment of Varicose Veins, MP-DE-1100 for additional requirements.
Stab phlebectomy of varicose veins, 1 extremity; 10-20 stab incisions	37765	Prior authorization is required. Please refer to Surgical Treatment of Varicose Veins, MP-DE-1100 for additional requirements.
Stab phlebectomy of varicose veins, 1 extremity; more than 20 incisions	37766	Prior authorization is required. Please refer to Surgical Treatment of Varicose Veins, MP-DE-1100 for additional requirements.
Ligation and division of short saphenous vein at saphenopopliteal junction (separate procedure)	37780	Prior authorization is required. Please refer to Surgical Treatment of Varicose Veins, MP-DE-1100 for additional requirements.
Ligation, division, and/or excision of varicose vein cluster(s), 1 leg	37785	Prior authorization is required. Please refer to Surgical Treatment of Varicose Veins, MP-DE-1100 for additional requirements.
Unlisted procedure, vascular surgery	37799	Prior authorization is required. Please refer to Surgical Treatment of Varicose Veins, MP-DE-1100 for additional requirements.
Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation	76942	Prior authorization is required. Please refer to Surgical Treatment of Varicose Veins, MP-DE-1100 for additional requirements.
Ultrasonic guidance, intraoperative	76998	Prior authorization is required. Please refer to Surgical Treatment of Varicose Veins, MP-DE-1100 for additional requirements.
Unclassified drugs	J3490	Prior authorization is required. Please refer to Surgical Treatment of Varicose Veins, MP-DE-1100 for additional requirements.
Liver Transplant	**Codes**	**Prior Authorization Requirement**
Liver allotransplantation, orthotopic, partial or whole, from cadaver or living donor, any age	47135	Prior authorization is required. Please refer to Liver Transplant, MP-DE-1124 for additional requirements.
Unlisted procedure, liver	47399	Prior authorization is required. Please refer to Liver Transplant, MP-DE-1124 for additional requirements.
Skin Replacement Therapy For Chronic Non healing Wounds in The Outpatient Setting	**Codes**	**Prior Authorization Requirement**
Autologous platelet rich plasma for nondiabetic chronic wounds/ulcers, including phlebotomy, centrifugation, and all other preparatory procedures, administration and dressings, per treatment	G0460	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.
Platelet rich plasma, each unit	P9020	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.
Red blood cells, washed, each unit	P9022	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.

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 The Outpatient Setting, MP-DE-1132 for additional requirements.
HYALOMATRIX, per sq cm	Q4117	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.
MatriStem micromatrix, 1 mg	Q4118	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.
DermACELL, DermACELL AWM or 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 The Outpatient Setting, MP-DE-1132 for additional requirements.
MemoDerm, DermaSpan, TranZgraft or InteguPly, per sq cm	Q4126	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.
Talymed, per sq cm	Q4127	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.
HMatrix, per sq cm	Q4134	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 The Outpatient Setting, MP-DE-1132 for additional requirements.
AmnioMatrix or BioDMatrix, injectable, 1 cc	Q4139	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, per sq cm	Q4140	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 The Outpatient Setting, MP-DE-1132 for additional requirements.
Tensix, per sq cm	Q4146	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.
Architect, Architect PX, or Architect FX, extracellular matrix, per sq cm	Q4147	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 Cord 1K, Neox Cord RT, or Clarix Cord 1K, per sq cm	Q4148	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.
Excellagen, 0.1 cc	Q4149	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.
AlloWrap DS or dry, per sq cm	Q4150	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 The Outpatient Setting, MP-DE-1132 for additional requirements.
Revitalon, per sq cm	Q4157	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.
Kerecis Omega3, per sq cm	Q4158	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.
Affinity, per sq cm	Q4159	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.
Nushield, per sq cm	Q4160	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 preparation when performed	0232T	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.
Percutaneous Left Atrial Appendage Closure (LAAC) Device	**Codes**	**Prior Authorization Requirement**
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**

Initial hospital care, per day, for the evaluation and management of a patient, 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 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 severity. 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.
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 interval history; 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.	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 hospital floor 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 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 hospital 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. Typically, 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 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.	99234	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 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. Typically, 50 minutes are spent at the bedside and on the patient's hospital floor or unit.	99235	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 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 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.	99236	Prior authorization is required. Please refer to Physician Certification and Recertification of Home Health Services, MP-DE-1143 for additional requirements.
Hospital discharge day management; 30 minutes or less	99238	Prior authorization is required. Please refer to Physician Certification and Recertification of Home Health Services, MP-DE-1143 for additional requirements.
Hospital discharge day management; more than 30 minutes	99239	Prior authorization is required. Please refer to Physician Certification and Recertification of Home Health Services, MP-DE-1143 for additional requirements.
Initial nursing facility care, per day, for the evaluation and management of a patient, 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.	99304	Prior authorization is required. Please refer to Physician Certification and Recertification of Home Health Services, MP-DE-1143 for additional requirements.
Initial nursing facility care, per day, for the evaluation and management of a patient, 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 problem(s) requiring admission are of moderate severity. Typically, 35 minutes are spent at the bedside and on the patient's facility floor or unit.	99305	Prior authorization is required. Please refer to Physician Certification and Recertification of Home Health Services, MP-DE-1143 for additional requirements.
Initial nursing facility care, per day, for the evaluation and management of a patient, 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 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 severity. Typically, 45 minutes are spent at the bedside and on the patient's facility floor or unit.	99306	Prior authorization is required. Please refer to Physician Certification and Recertification of Home Health Services, MP-DE-1143 for additional requirements.
Subsequent nursing facility 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; 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 patient is stable, recovering, or improving. Typically, 10 minutes are spent at the bedside and on the patient's facility floor or unit.	99307	Prior authorization is required. Please refer to Physician Certification and Recertification of Home Health Services, MP-DE-1143 for additional requirements.

Subsequent nursing facility 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 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.	99308	Prior authorization is required. Please refer to Physician Certification and Recertification of Home Health Services, MP-DE-1143 for additional requirements.
Subsequent nursing facility 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 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.	99309	Prior authorization is required. Please refer to Physician Certification and Recertification of Home Health Services, MP-DE-1143 for additional requirements.
Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key 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.	99310	Prior authorization is required. Please refer to Physician Certification and Recertification of Home Health Services, MP-DE-1143 for additional requirements.
Evaluation and management of a patient involving an annual nursing facility assessment, which requires these 3 key 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.	99318	Prior authorization is required. Please refer to Physician Certification and Recertification of Home Health Services, MP-DE-1143 for additional requirements.
Home visit for the evaluation and management of a new patient, which requires these 3 key components: A problem focused 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-to-face with the patient and/or family.	99341	Prior authorization is required. Please refer to Physician Certification and Recertification of Home Health Services, MP-DE-1143 for additional requirements.
Home visit for the evaluation and management of a new patient, which requires these 3 key components: An expanded 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.	99342	Prior authorization is required. Please refer to Physician Certification and Recertification of Home Health Services, MP-DE-1143 for additional requirements.
Home visit for the evaluation and management of a new patient, which requires 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.	99343	Prior authorization is required. Please refer to Physician Certification and Recertification of Home Health Services, MP-DE-1143 for additional requirements.
Home visit for the evaluation and management of a new patient, 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) are of high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.	99344	Prior authorization is required. Please refer to Physician Certification and Recertification of Home Health Services, MP-DE-1143 for additional requirements.

Home visit for the evaluation and management of a new patient, 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 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.	99345	Prior authorization is required. Please refer to Physician Certification and Recertification of Home Health Services, MP-DE-1143 for additional requirements.
Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key 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.	99347	Prior authorization is required. Please refer to Physician Certification and Recertification of Home Health Services, MP-DE-1143 for additional requirements.
Home visit for the evaluation and management of an established 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 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.	99348	Prior authorization is required. Please refer to Physician Certification and Recertification of Home Health Services, MP-DE-1143 for additional requirements.
Home visit for the evaluation and management of an established patient, 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 presenting problem(s) are moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.	99349	Prior authorization is required. Please refer to Physician Certification and Recertification of Home Health Services, MP-DE-1143 for additional requirements.
Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key 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.	99350	Prior authorization is required. Please refer to Physician Certification and Recertification of Home Health Services, MP-DE-1143 for additional requirements.
External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing	**Codes**	**Prior Authorization Requirement**
Craniectomy for excision of brain tumor, infratentorial or posterior fossa; cerebellopontine angle tumor	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.
Craniectomy, bone flap craniotomy, transtemporal (mastoid) for excision of cerebellopontine angle tumor; combined with middle/posterior fossa craniotomy/craniectomy	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.
Transpetrosal approach to posterior cranial fossa, clivus or foramen magnum, including ligation of superior petrosal sinus and/or sigmoid sinus	61598	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.
Implantation, osseointegrated implant, skull; with percutaneous attachment to external speech processor	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.
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 additional requirements.
HEAR AID MONAURL BDY WORN BN CONDCT	V5040	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	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 BEHIND THE EAR	V5060	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.
GLASSES AIR CONDUCTION	V5070	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.
GLASSES BONE CONDUCTION	V5080	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 BILATERAL BODY WORN	V5100	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 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 additional requirements.
HA CONTRALAT RS BINAURAL ITE/ITE	V5211	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 RS BINAURAL ITE/ITE	V5212	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 CONTRA RTE SYS BINAURAL ITE/ITC	V5213	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 CONTRA ROUT SYS BINAURAL ITE/BTE	V5214	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 CONTRA ROUT SYS BINAURAL ITC/ITC	V5215	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 CONTRA ROUT SYS BINAURAL ITC/BTE	V5221	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 SYS BINAUR GLASSES	V5230	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 MONAURAL CIC	V5242	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 MONAURAL ITC	V5243	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 CIC	V5244	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 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	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 additional requirements.
HEARING AID DIGITAL MONAURAL ITC	V5255	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 additional requirements.
HEARING AID DIGITAL MONAURAL BTE	V5257	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 BINAURAL CIC	V5258	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 BINAURAL ITC	V5259	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 BINAURAL ITE	V5260	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 BINAURAL BTE	V5261	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 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	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**	**Prior Authorization Requirement**
	No specific codes listed	Prior authorization is required. Please refer to Testing for Genetic Disease, MP-DE-1205 for additional requirements.
Genetic Testing for Colorectal Cancer Susceptibility	**Codes**	**Prior Authorization Requirement**
APC (adenomatous polyposis coli) (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; known familial variants	81202	Prior authorization is required. Please refer to Genetic Testing for Colorectal Cancer Susceptibility, MP-DE-1207 for additional requirements.
APC (adenomatous polyposis coli) (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; duplication/deletion variants	81203	Prior authorization is required. Please refer to Genetic Testing for Colorectal Cancer Susceptibility, MP-DE-1207 for additional requirements.
Microsatellite instability analysis (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) of markers for mismatch repair deficiency (eg, BAT25, BAT26), includes comparison of neoplastic and normal tissue, if performed	81301	Prior authorization is required. Please refer to Genetic Testing for Colorectal Cancer Susceptibility, MP-DE-1207 for additional requirements.
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 chromosomes 13, 18, and 21	81420	Prior authorization is required. Please refer to Fetal Aneuploidy Testing Using Noninvasive Cell-Free Fetal DNA, MP-DE-1208 for additional requirements.
Fetal aneuploidy (trisomy 21, 18, and 13) DNA sequence analysis of selected regions using maternal plasma, algorithm reported as a risk score for each trisomy	81507	Prior authorization is required. Please refer to Fetal Aneuploidy Testing Using Noninvasive Cell-Free Fetal DNA, MP-DE-1208 for additional requirements.
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 (eg, 2, 3, 5, 6)	81227	Prior authorization is required. Please refer to Chromosomal Microarray Analysis, Comparative Genomic Hybridization and Single Nucleotide Polymorphism, MP-DE-1209 for additional requirements.
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	81401	Prior authorization is required. Please refer to Oncologic Genetic Testing Panels , MP-DE-1210 for additional requirements.
MOLECULAR PATHOLOGY PROCEDURE LEVEL 5	81404	Prior authorization is required. Please refer to Oncologic Genetic Testing Panels , MP-DE-1210 for additional requirements.
Hereditary breast cancer-related disorders (eg, hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer); genomic sequence analysis panel, must include sequencing of at least 10 genes, always including BRCA1, BRCA2, CDH1, MLH1, MSH2, MSH6, PALB2, PTEN, STK11, and TP53	81432	Prior authorization is required. Please refer to Oncologic Genetic Testing Panels , MP-DE-1210 for additional 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.

Unlisted molecular pathology procedure	81479	Prior authorization is required. Please refer to Oncologic Genetic Testing Panels , MP-DE-1210 for additional requirements.
Oncology (tissue of origin), microarray gene expression profiling of > 2000 genes, utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as tissue similarity scores	81504	Prior authorization is required. Please refer to Oncologic Genetic Testing Panels , MP-DE-1210 for additional requirements.
Oncology (breast), mRNA gene expression profiling by hybrid capture of 58 genes (50 content and 8 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a recurrence risk score	81520	Prior authorization is required. Please refer to Oncologic Genetic Testing Panels , MP-DE-1210 for additional requirements.
Oncology (breast), mRNA, microarray gene expression profiling of 70 content genes and 465 housekeeping genes, utilizing fresh frozen or formalin-fixed paraffin-embedded tissue, algorithm reported as index related to risk of distant metastasis	81521	Prior authorization is required. Please refer to Oncologic Genetic Testing Panels , MP-DE-1210 for additional requirements.
Oncology (tumor of unknown origin), mRNA, gene expression profiling by real-time RT-PCR of 92 genes (87 content and 5 housekeeping) to classify tumor into main cancer type and subtype, utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a probability of a predicted main cancer type and subtype	81540	Prior authorization is required. Please refer to Oncologic Genetic Testing Panels , MP-DE-1210 for additional 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 requirements.
Gene expression profiling panel for use in the management of breast cancer treatment	S3854	Prior authorization is required. Please refer to Oncologic Genetic Testing Panels , MP-DE-1210 for additional requirements.
Labiaplasty	**Codes**	**Prior Authorization Requirement**
Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area	15839	Prior authorization is required. Please refer to Labiaplasty, MP-DE-1215 for additional requirements.
Unlisted procedure, female genital system (nonobstetrical)	58999	Prior authorization is required. Please refer to Labiaplasty, MP-DE-1215 for additional requirements.
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 requirements.
Revision (including removal) of prosthetic vaginal graft; vaginal approach	57295	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 tube(s), with or without removal of ovary(s)	58150	Prior authorization is required. Please refer to Gender Affirmation Services, MP-DE-1216 for additional requirements.
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) and/or ovary(s)	58291	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	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; with removal of tube(s) and/or ovary(s)	58542	Prior authorization is required. Please refer to Gender Affirmation Services, MP-DE-1216 for additional requirements.
Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g;	58543	Prior authorization is required. Please refer to Gender Affirmation Services, MP-DE-1216 for additional requirements.
Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)	58544	Prior authorization is required. Please refer to Gender Affirmation Services, MP-DE-1216 for additional requirements.
Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less;	58550	Prior authorization is required. Please refer to Gender Affirmation Services, MP-DE-1216 for additional requirements.
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. Please refer to Gender Affirmation Services, MP-DE-1216 for additional 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.
Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g	58572	Prior authorization is required. Please refer to Gender Affirmation Services, MP-DE-1216 for additional requirements.
Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)	58573	Prior authorization is required. Please refer to Gender Affirmation Services, MP-DE-1216 for additional requirements.
Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)	58661	Prior authorization is required. Please refer to Gender Affirmation Services, MP-DE-1216 for additional requirements.

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 or less	14000	Prior authorization is required. Please refer to Gender Affirmation Services, MP-DE-1216 for additional requirements.
Adjacent tissue transfer or rearrangement, trunk; defect 10.1 sq. cm to 30.0 sq. cm	14001	Prior authorization is required. Please refer to Gender Affirmation Services, MP-DE-1216 for additional requirements.
Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10.1 sq. cm to 30.0 sq. cm	14041	Prior authorization is required. Please refer to Gender Affirmation Services, MP-DE-1216 for additional requirements.
Implantation of biologic implant (e.g., acellular dermal matrix) for soft tissue reinforcement (i.e. breast, trunk) (List separately in addition to code for primary procedure	15777	Prior authorization is required. Please refer to Gender Affirmation Services, MP-DE-1216 for additional 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; radiofrequency	32998	Prior authorization is required. Please refer to Radiofrequency Ablation of Miscellaneous Solid Tumors, Excluding Liver Tumors, MP-DE-1218 for additional requirements.
Per-Oral Endoscopic Myotomy	**Codes**	**Prior Authorization Requirement**
Unlisted procedure, esophagus	43499	Prior authorization is required. Please refer to Per-Oral Endoscopic Myotomy, MP-DE-1226 for additional requirements.
Transcatheter Closure Devices for Septal Defects	**Codes**	**Prior Authorization Requirement**
Percutaneous transcatheter closure of congenital interatrial communication (ie, Fontan fenestration, atrial septal defect) with implant	93580	Prior authorization is required. Please refer to Transcatheter Closure Devices for Septal Defects, MP-DE-1234 for additional requirements.
Percutaneous transcatheter closure of a congenital ventricular septal defect with implant	93581	Prior authorization is required. Please refer to Transcatheter Closure Devices for Septal Defects, MP-DE-1234 for additional requirements.
Percutaneous transcatheter closure of patent ductus arteriosus	93582	Prior authorization is required. Please refer to Transcatheter Closure Devices for Septal Defects, MP-DE-1234 for additional requirements.
Gastric Electrical Stimulation and Gastric Pacing	**Codes**	**Prior Authorization Requirement**
Laparoscopy, surgical; implantation or replacement of gastric neurostimulator electrodes, antrum	43647	Prior authorization is required. Please refer to Gastric Electrical Stimulation and Gastric Pacing, MP-DE-1235 for additional requirements.
Laparoscopy, surgical; revision or removal of gastric neurostimulator electrodes, antrum	43648	Prior authorization is required. Please refer to Gastric Electrical Stimulation and Gastric Pacing, MP-DE-1235 for additional requirements.
Implantation or replacement of gastric neurostimulator electrodes, antrum, open	43881	Prior authorization is required. Please refer to Gastric Electrical Stimulation and Gastric Pacing, MP-DE-1235 for additional requirements.
Revision or removal of gastric neurostimulator electrodes, antrum, open	43882	Prior authorization is required. Please refer to Gastric Electrical Stimulation and Gastric Pacing, MP-DE-1235 for additional requirements.
Insertion or replacement of peripheral or gastric neurostimulator pulse generator or receiver, direct or inductive coupling	64590	Prior authorization is required. Please refer to Gastric Electrical Stimulation and Gastric Pacing, MP-DE-1235 for additional requirements.
Revision or removal of peripheral or gastric neurostimulator pulse generator or receiver	64595	Prior authorization is required. Please refer to Gastric Electrical Stimulation and Gastric Pacing, MP-DE-1235 for additional requirements.
Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; intraoperative, with programming	95980	Prior authorization is required. Please refer to Gastric Electrical Stimulation and Gastric Pacing, MP-DE-1235 for additional requirements.
Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; subsequent, without reprogramming	95981	Prior authorization is required. Please refer to Gastric Electrical Stimulation and Gastric Pacing, MP-DE-1235 for additional requirements.
Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; subsequent, with reprogramming	95982	Prior authorization is required. Please refer to Gastric Electrical Stimulation and Gastric Pacing, MP-DE-1235 for additional requirements.
Autism Spectrum Disorders	**Codes**	**Prior Authorization Requirement**

Psychological testing evaluation 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, first hour	96130	Please refer to Autism Spectrum Disorders, MP-DE-1045 for additional requirements.
Psychological testing evaluation 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)	96131	Please refer to Autism Spectrum Disorders, MP-DE-1045 for additional requirements.
Neuropsychological testing evaluation 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; first hour	96132	Please refer to Autism Spectrum Disorders, MP-DE-1045 for additional requirements.
Neuropsychological testing evaluation 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)	96133	Please refer to Autism Spectrum Disorders, MP-DE-1045 for additional requirements.
Psychological or neuropsychological test administration and scoring by physicians or other qualified health care professional, two or more tests, any method; first 30 minutes	96136	Please refer to Autism Spectrum Disorders, MP-DE-1045 for additional requirements.
Psychological or neuropsychological test 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)	96137	Please refer to Autism Spectrum Disorders, MP-DE-1045 for additional requirements.
Psychological or neuropsychological test administration, with single automated, standardized instrument via electronic platform, with automated result only	96146	Please refer to Autism Spectrum Disorders, MP-DE-1045 for additional requirements.

Carpal Tunnel Surgery	**Codes**	**Prior Authorization Requirement**
Endoscopy, wrist, surgical, with release of transverse carpal ligament	29848	Prior authorization is required, refer to Carpal Tunnel, MP-DE-1038 for additional requirements.
Neuroplasty and/or transposition; median nerve at carpal tunnel	64721	Prior authorization is required, refer to Carpal Tunnel, MP-DE-1038 for additional requirements.

Diagnosis and Treatment of Obstructive Sleep Apnea in Adults	**Codes**	**Prior Authorization Requirement**
Multiple sleep latency or maintenance of wakefulness testing, recording, analysis and interpretation of physiological measurements of sleep during multiple trials to assess sleepiness	95805	Prior authorization is required. Please refer to Diagnosis and Treatment of Obstructive Sleep Apnea in Adults, MP-DE-1064 for additional requirements
Sleep study, unattended, simultaneous recording of, heart rate, oxygen saturation, respiratory airflow, and respiratory effort (eg, thoracoabdominal movement)	95806	Prior authorization is required. Please refer to Diagnosis and Treatment of Obstructive Sleep Apnea in Adults, MP-DE-1064 for additional requirements
Sleep study, simultaneous recording of ventilation, respiratory effort, ECG or heart rate, and oxygen saturation, attended by a technologist	95807	Prior authorization is required. Please refer to Diagnosis and Treatment of Obstructive Sleep Apnea in Adults, MP-DE-1064 for additional requirements
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 Adults, MP-DE-1064 for additional requirements
Polysomnography; age 6 years or older, sleep staging with 4 or more additional parameters of sleep, attended by a technologist	95810	Prior authorization is required. Please refer to Diagnosis and Treatment of Obstructive Sleep Apnea in Adults, MP-DE-1064 for additional requirements
Polysomnography; age 6 years or older, sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bilevel ventilation, attended by a technologist	95811	Prior authorization is required. Please refer to Diagnosis and Treatment of Obstructive Sleep Apnea in Adults, MP-DE-1064 for additional requirements
Genioplasty; sliding osteotomies, 2 or more osteotomies (eg, wedge excision or bone wedge reversal for asymmetrical chin)	21122	Prior authorization is required. Please refer to Diagnosis and Treatment of Obstructive Sleep Apnea in Adults, MP-DE-1064 for additional requirements
Genioplasty; sliding, augmentation with interpositional bone grafts (includes obtaining autografts)	21123	Prior authorization is required. Please refer to Diagnosis and Treatment of Obstructive Sleep Apnea in Adults, MP-DE-1064 for additional requirements
Reconstruction of mandibular rami and/or body, sagittal split; without internal rigid fixation	21195	Prior authorization is required. Please refer to Diagnosis and Treatment of Obstructive Sleep Apnea in Adults, MP-DE-1064 for additional requirements
Reconstruction of mandibular rami and/or body, sagittal split; with internal rigid fixation	21196	Prior authorization is required. Please refer to Diagnosis and Treatment of Obstructive Sleep Apnea in Adults, MP-DE-1064 for additional requirements
Osteotomy, mandible, segmental; with genioglossus advancement	21199	Prior authorization is required. Please refer to Diagnosis and Treatment of Obstructive Sleep Apnea in Adults, MP-DE-1064 for additional requirements
Hyoid myotomy and suspension	21685	Prior authorization is required. Please refer to Diagnosis and Treatment of Obstructive Sleep Apnea in Adults, MP-DE-1064 for additional requirements
Excision inferior turbinate, partial or complete, any method	30130	Prior authorization is required. Please refer to Diagnosis and Treatment of Obstructive Sleep Apnea in Adults, MP-DE-1064 for additional requirements
Submucous resection inferior turbinate, partial or complete, any method	30140	Prior authorization is required. Please refer to Diagnosis and Treatment of Obstructive Sleep Apnea in Adults, MP-DE-1064 for additional requirements
Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft	30520	Prior authorization is required. Please refer to Diagnosis and Treatment of Obstructive Sleep Apnea in Adults, MP-DE-1064 for additional requirements

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, MP-DE-1064 for additional requirements
Glossectomy; hemiglossectomy	41130	Prior authorization is required. Please refer to Diagnosis and Treatment of Obstructive Sleep Apnea in Adults, MP-DE-1064 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 Adults, MP-DE-1064 for additional requirements
Submucosal ablation of the tongue base, radiofrequency, 1 or more sites, per session	41530	Prior authorization is required. Please refer to Diagnosis and Treatment of Obstructive Sleep Apnea in Adults, 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 over	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, MP-DE-1064 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 Adults, MP-DE-1064 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 Adults, MP-DE-1064 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 Adults, MP-DE-1064 for additional requirements
Unlisted procedure, pharynx, adenoids, or tonsils	42999	Prior authorization is required. Please refer to Diagnosis and Treatment of Obstructive Sleep Apnea in Adults, 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, including connection to existing pulse generator	64569	Prior authorization is required. Please refer to Diagnosis and Treatment of Obstructive Sleep Apnea in Adults, MP-DE-1064 for additional 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 Sleep Apnea in Pediatric Individuals	**Codes**	**Prior Authorization Requirement**
Multiple sleep latency or maintenance of wakefulness testing, recording, analysis and interpretation of physiological measurements of sleep during multiple trials to assess sleepiness	95805	Prior authorization is required. Please refer to Diagnosis and Treatment of Obstructive Sleep Apnea in Pediatric Individuals, MP-DE-1065 for additional requirements
Sleep study, unattended, simultaneous recording of, heart rate, oxygen saturation, respiratory airflow, and respiratory effort (eg, thoracoabdominal movement)	95806	Prior authorization is required. Please refer to Diagnosis and Treatment of Obstructive Sleep Apnea in Pediatric Individuals, MP-DE-1065 for additional requirements
Sleep study, simultaneous recording of ventilation, respiratory effort, ECG or heart rate, and oxygen saturation, attended by a technologist	95807	Prior authorization is required. Please refer to Diagnosis and Treatment of Obstructive Sleep Apnea in Pediatric Individuals, MP-DE-1065 for additional requirements
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 technologist	95810	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, with initiation of continuous positive airway pressure therapy or bilevel ventilation, attended by a technologist	95811	Prior authorization is required. Please refer to Diagnosis and Treatment of Obstructive Sleep Apnea in Pediatric Individuals, MP-DE-1065 for additional requirements
Circadian respiratory pattern recording (pediatric pneumogram), 12-24 hour continuous recording, infant	94772	Prior authorization is required. Please refer to Diagnosis and Treatment of Obstructive Sleep Apnea in Pediatric Individuals, MP-DE-1065 for additional requirements
Polysomnography; younger than 6 years, sleep staging with 4 or more additional parameters of sleep, attended by a technologist	95782	Prior authorization is required. Please refer to Diagnosis and Treatment of Obstructive Sleep Apnea in Pediatric Individuals, MP-DE-1065 for additional requirements
Polysomnography; younger than 6 years, sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bi-level ventilation, attended by a technologist	95783	Prior authorization is required. Please refer to Diagnosis and Treatment of Obstructive Sleep Apnea in Pediatric Individuals, MP-DE-1065 for additional requirements
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 Apnea in Pediatric Individuals, MP-DE-1065 for additional requirements
Oral device/appliance used to reduce upper airway collapsibility, adjustable or nonadjustable, prefabricated, includes fitting and adjustment	E0485	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
Oral device/appliance used to reduce upper airway collapsibility, adjustable or nonadjustable, custom fabricated, includes fitting and adjustment	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
Tracheostomy, planned (separate procedure);	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, radiofrequency, 1 or more sites, per session	41530	Prior authorization is required. Please refer to Diagnosis and Treatment of Obstructive Sleep Apnea in Pediatric Individuals, MP-DE-1065 for additional requirements
Uvulectomy, excision of uvula	42140	Prior authorization is required. Please refer to Diagnosis and Treatment of Obstructive Sleep Apnea in Pediatric Individuals, MP-DE-1065 for additional requirements
Palatopharyngoplasty (eg, uvulopalatopharyngoplasty, uvulopharyngoplasty)	42145	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; 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 than age 12	42825	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; age 12 or over	42826	Prior authorization is required. Please refer to Diagnosis and Treatment of Obstructive Sleep Apnea in Pediatric Individuals, MP-DE-1065 for additional requirements
Adenoidectomy, primary; younger than age 12	42830	Prior authorization is required. Please refer to Diagnosis and Treatment of Obstructive Sleep Apnea in 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 Pediatric Individuals, MP-DE-1065 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 Pediatric Individuals, MP-DE-1065 for additional requirements
Revision or replacement of cranial nerve (eg, vagus nerve) neurostimulator electrode array, including connection to existing pulse generator	64569	Prior authorization is required. Please refer to Diagnosis and Treatment of Obstructive Sleep Apnea in Pediatric Individuals, MP-DE-1065 for additional requirements
Removal of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator	64670	Prior authorization is required. Please refer to Diagnosis and Treatment of Obstructive Sleep Apnea in Pediatric Individuals, MP-DE-1065 for additional requirements
Polysomnography (PSG) for Non-Respiratory Sleep Disorder	**Codes**	**Prior Authorization Requirement**
Polysomnography; younger than 6 years, sleep staging with 4 or more additional parameters of sleep, attended by a technologist	95782	Prior authorization is required. Please refer to Polysomnography (PSG) for Non-Respiratory Sleep Disorder, MP-DE-1073 for additional requirements
Polysomnography; younger than 6 years, sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bi-level ventilation, attended by a technologist	95783	Prior authorization is required. Please refer to Polysomnography (PSG) for Non-Respiratory Sleep Disorder, MP-DE-1073 for additional requirements
Multiple sleep latency or maintenance of wakefulness testing, recording, analysis and interpretation of physiological measurements of sleep during multiple trials to assess sleepiness	95805	Prior authorization is required. Please refer to Polysomnography (PSG) for Non-Respiratory Sleep Disorder, MP-DE-1073 for additional requirements
Polysomnography; any age, sleep staging with 1-3 additional parameters of sleep, attended by a technologist	95808	Prior authorization is required. Please refer to Polysomnography (PSG) for Non-Respiratory Sleep Disorder, MP-DE-1073 for additional requirements
Polysomnography; age 6 years or older, sleep staging with 4 or more additional parameters of sleep, attended by a technologist	95810	Prior authorization is required. Please refer to Polysomnography (PSG) for Non-Respiratory Sleep Disorder, MP-DE-1073 for additional requirements
Polysomnography; age 6 years or older, sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bilevel ventilation, attended by a technologist	95811	Prior authorization is required. Please refer to Polysomnography (PSG) for Non-Respiratory Sleep Disorder, MP-DE-1073 for additional requirements
Private Duty Nursing	**Codes**	**Prior Authorization Requirement**
Nursing care, in the home; by registered nurse, per hour	S9123	Prior authorization is required. Please see Private Duty Nursing, MP-DE-1128 for additional requirements.
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	S9125	Prior authorization is required. Please see Private Duty Nursing, MP-DE-1128 for additional requirements.
Private duty/independent nursing service(s), licensed, up to 15 minutes	T1000	Prior authorization is required. Please see Private Duty Nursing, MP-DE-1128 for additional requirements.
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, automated, worn continuously for 24 hours or longer; including recording, scanning analysis, interpretation and report	93784	Prior authorization is required. For additional information please reference Ambulatory Blood Pressure Monitors, MP-DE-1032
Ambulatory blood pressure monitoring, utilizing report-generating software, automated, worn continuously for 24 hours or longer; recording only	93786	Prior authorization is required. For additional information please reference Ambulatory Blood Pressure Monitors, MP-DE-1032
Ambulatory blood pressure monitoring, utilizing report-generating software, automated, worn continuously for 24 hours or longer; scanning analysis with report	93788	Prior authorization is required. For additional information please reference Ambulatory Blood Pressure Monitors, MP-DE-1032
Ambulatory blood pressure monitoring, utilizing report-generating software, automated, worn continuously for 24 hours or longer; review with interpretation and report	93790	Prior authorization is required. For additional information please reference Ambulatory Blood Pressure Monitors, MP-DE-1032
Hyperbaraic Oxygen Therapy	**Codes**	**Prior Authorization Requirement**
Physician or other qualified health care professional attendance and supervision of hyperbaric oxygen therapy, per session	99183	Prior authorization is required. For additional information please reference Hyperbaraic Oxygen Therapy, MP-DE-1029
ECMO	**Codes**	**Prior Authorization Requirement**
Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; initiation, veno-venous	33946	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; initiation, veno-arterial	33947	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; daily management, each day, veno-venous	33948	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; daily management, each day, veno-arterial	33949	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; insertion of peripheral (arterial and/or venous) cannula(e), percutaneous, birth through 5 years of age (includes fluoroscopic guidance, when performed)	33951	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; insertion of peripheral (arterial and/or venous) cannula(e), open, birth through 5 years of age	33953	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; insertion of peripheral (arterial and/or venous) cannula(e), open, 6 years and older	33954	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; insertion of central cannula(e) by sternotomy or thoracotomy, birth through 5 years of age	33955	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; 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)/extracorporeal life support (ECLS) provided by physician; reposition peripheral (arterial and/or venous) cannula(e), 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 fluoroscopic guidance, when performed)	33958	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), open, birth through 5 years of age (includes fluoroscopic guidance, when performed)	33959	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), 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
Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided 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	33965	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, 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	33988	Prior authorization is required. For additional information please reference Extracorporeal Membrane Oxygenation (ECMO), MP-DE-1061
Removal of left heart vent by thoracic incision (eg, sternotomy, thoracotomy) for ECMO/ECLS	33989	Prior authorization is required. For additional information please reference Extracorporeal Membrane Oxygenation (ECMO), MP-DE-1061
Wireless Capsule Endoscopy as a Diagnostic Technique in Disorders of the Small Bowel, Esophagus, and Colon	**Codes**	**Prior Authorization Requirement**
Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus through ileum, with interpretation and report	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.
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	91113	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.
Unlisted diagnostic gastroenterology procedure	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.
Donor Leukocyte Infusion for Hematologic Malignancies that Relapse after Allogeneic Cell Transplantation	**Codes**	**Prior Authorization Requirement**
Therapeutic apheresis; for white blood cells	36511	Prior authorization is required. For additional information please reference Donor Leukocyte Infusion for Hematologic Malignancies that Relapse after Allogeneic Cell Transplantation , MP-DE-1019
Allogeneic lymphocyte infusions	38242	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
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 augmentation device	43285	Prior authorization is required. For additional information please reference Magnetic Esophageal Ring to Treat Gastroesophageal Reflux Disease (LINX), MP-DE-1023
Unlisted laparoscopy procedure, esophagus	43289	Prior authorization is required. For additional information please reference Magnetic Esophageal Ring to Treat Gastroesophageal Reflux Disease (LINX), MP-DE-1023
Treatment of Malignant Skin Lesions	**Codes**	**Prior Authorization Requirement**
Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic 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 surgery directly involving muscle, cartilage, bone, tendon, major nerves, 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 tissue specimens, mapping, color coding of specimens, microscopic 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 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
Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine 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, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, 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
Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, 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	96567	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) (ie, targeted curettage, abrasion) followed with 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	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 cardiectomy	33927	Prior authorization is required. For additional information please reference Artificial Hearts and Ventricular Assist Devices, MP-DE-1104
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 procedure)	33929	Prior authorization is required. For additional information please reference Artificial Hearts and Ventricular Assist Devices, MP-DE-1104
Insertion of ventricular assist device; extracorporeal, single ventricle	33975	Prior authorization is required. For additional information please reference Artificial Hearts and Ventricular 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; extracorporeal, single ventricle	33977	Prior authorization is required. For additional information please reference Artificial Hearts and Ventricular Assist Devices, MP-DE-1104
Removal of ventricular assist device; extracorporeal, biventricular	33978	Prior authorization is required. For additional information please reference Artificial Hearts and Ventricular 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, implantable intracorporeal, single ventricle	33980	Prior authorization is required. For additional information please reference Artificial Hearts and Ventricular Assist Devices, MP-DE-1104
Replacement of extracorporeal ventricular assist device, single or biventricular, pump(s), single or each pump	33981	Prior authorization is required. For additional information please reference Artificial Hearts and Ventricular Assist Devices, MP-DE-1104
Replacement of ventricular assist device pump(s); implantable intracorporeal, single ventricle, without cardiopulmonary bypass	33982	Prior authorization is required. For additional information please reference Artificial Hearts and Ventricular Assist Devices, MP-DE-1104
Replacement of ventricular assist device pump(s); implantable intracorporeal, single ventricle, with cardiopulmonary bypass	33983	Prior authorization is required. For additional information please reference Artificial Hearts and Ventricular Assist Devices, MP-DE-1104
Insertion of ventricular assist device, percutaneous, including radiological supervision and interpretation; left heart, arterial access only	33990	Prior authorization is required. For additional information please reference Artificial Hearts and Ventricular Assist Devices, MP-DE-1104
Insertion of ventricular assist device, percutaneous, including radiological supervision and interpretation; left heart, both arterial and venous access, with transseptal puncture	33991	Prior authorization is required. For additional information please reference Artificial Hearts and Ventricular Assist Devices, MP-DE-1104
Removal of percutaneous left heart ventricular assist device, arterial or arterial and venous cannula(s), at separate and distinct session from insertion	33992	Prior authorization is required. For additional information please reference Artificial Hearts and Ventricular Assist Devices, MP-DE-1104
Repositioning of percutaneous right or left heart ventricular assist device with imaging guidance at separate and distinct session from insertion	33993	Prior authorization is required. For additional information please reference Artificial Hearts and Ventricular Assist Devices, MP-DE-1104
Insertion of ventricular assist device, percutaneous, including radiological supervision and interpretation; right heart, venous access only	33995	Prior authorization is required. For additional information please reference Artificial Hearts and Ventricular Assist Devices, MP-DE-1104
Removal of percutaneous right heart ventricular assist device, venous cannula, at separate and distinct session from insertion	33997	Prior authorization is required. For additional information please reference Artificial Hearts and Ventricular 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 qualified health care professional analysis of device parameters (eg, drivelines, alarms, power surges), review of device function (eg, flow and volume status, septum status, recovery), with programming, if performed, and report	93750	Prior authorization is required. For additional information please reference Artificial Hearts and Ventricular Assist Devices, MP-DE-1104
Miscellaneous component, supply or accessory for use with total artificial heart system	L8698	Prior authorization is required for billed charges greater than $500. For additional information please reference Artificial Hearts and Ventricular Assist Devices, MP-DE-1104
Cardiac Rehab	**Codes**	**Prior Authorization Requirement**
Physician or other qualified health care professional services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session)	93798	Prior authorization is required. For additional information please reference Cardiac Rehab, MP-DE-1026
Treatment of Twin-Twin Transfusion Syndrome with Amnioreductionand/or Fetoscopic Laser Therapy	**Codes**	**Prior Authorization Requirement**
Unlisted diagnostic radiographic procedure	76499	Prior authorization is required. For additional information please reference Treatment of Twin-Twin Transfusion Syndrome with Amnioreductionand/or Fetoscopic Laser Therapy, MP-DE-1043
Unlisted ultrasound procedure (eg, diagnostic, interventional)	76999	Prior authorization is required. For additional information please reference Treatment of Twin-Twin Transfusion Syndrome with Amnioreductionand/or Fetoscopic Laser Therapy, MP-DE-1043
Amniocentesis; therapeutic amniotic fluid reduction (includes ultrasound guidance)	59001	Prior authorization is required. For additional information please reference Treatment of Twin-Twin Transfusion Syndrome with Amnioreductionand/or Fetoscopic Laser Therapy, MP-DE-1043
Recombinant and Autologous Platelet-Derived Growth Factors for Wound Healing and Other Non-Orthopedic Conditions	**Codes**	**Prior Authorization Requirement**
Unlisted transfusion medicine procedure	86999	Prior authorization is required. For additional information please reference Recombinant and Autologous Platelet-Derived Growth Factors for Wound Healing and Other Non-Orthopedic Conditions, MP-DE-1053
Autologous platelet rich plasma for nondiabetic chronic wounds/ulcers, including phlebotomy, centrifugation, and all other preparatory procedures, administration and dressings, per treatment	G0460	Prior authorization is required. For additional information please reference Recombinant and Autologous Platelet-Derived Growth Factors for Wound Healing and Other Non-Orthopedic Conditions, MP-DE-1053
Biochemical Markers of Bone Remodeling	**Codes**	**Prior Authorization Requirement**
Collagen cross links, any method	82523	Prior authorization is required. For additional information please reference Biochemical Markers of Bone Remodeling, MP-DE-1016
Osteocalcin (bone g1a protein)	83937	Prior authorization is required. For additional information please reference Biochemical Markers of Bone Remodeling, MP-DE-1016
Cyanocobalamin (Vitamin B-12);	82607	Prior authorization is required. For additional information please reference Biochemical Markers of Bone Remodeling, MP-DE-1016
Cyanocobalamin (Vitamin B-12); unsaturated binding capacity	82608	Prior authorization is required. For additional information please reference Biochemical Markers of Bone Remodeling, MP-DE-1016
Homocysteine	83090	Prior authorization is required. For additional information please reference Biochemical Markers of Bone Remodeling, MP-DE-1016
Ultrasound bone density measurement and interpretation, peripheral site(s), any method	76977	Prior authorization is required. For additional information please reference Biochemical Markers of Bone Remodeling, MP-DE-1016
Computed tomography, bone mineral density study, 1 or more sites, axial skeleton (eg, hips, pelvis, spine)	77078	Prior authorization is required. For additional information please reference Biochemical Markers of Bone Remodeling, MP-DE-1016
Phosphatase, alkaline; isoenzymes	84080	Prior authorization is required. For additional information please reference Biochemical Markers of Bone Remodeling, MP-DE-1016
Allogeneic Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemia	**Codes**	**Prior Authorization Requirement**
Bone marrow harvesting for transplantation; allogeneic	38230	Prior authorization is required. For additional information please reference Allogeneic Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemia, MP-DE-1098
Hematopoietic progenitor cell (HPC); allogeneic transplantation per donor	38240	Prior authorization is required. For additional information please reference Allogeneic Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemia, MP-DE-1098
Hematopoietic Cell Transplantation (HCT) for Autoimmune Diseases	**Codes**	**Prior Authorization Requirement**
Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; autologous	38206	Prior authorization is required. For additional information please reference Hematopoietic Cell Transplantation (HCT) for Autoimmune Diseases, MP-DE-1103

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); autologous transplantation	38241	Prior authorization is required. For additional information please reference Hematopoietic Cell Transplantation (HCT) for Autoimmune Diseases, MP-DE-1103
Bone marrow harvesting for transplantation; allogeneic	38230	Prior authorization is required. For additional information please reference Hematopoietic Cell 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 Transplantation (HCT) for Autoimmune Diseases, MP-DE-1103
Hematopoietic Cell Transplantation for CNS Embryonal Tumors and Ependymoma	**Codes**	**Prior Authorization Requirement**
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); allogeneic transplantation per donor	38240	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); autologous transplantation	38241	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; 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 Chronic Myeloid Leukemia	**Codes**	**Prior Authorization Requirement**
Bone marrow harvesting for transplantation; allogeneic	38230	Prior authorization is required. For additional information please reference Hematopoietic Cell 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); autologous transplantation	38241	Prior authorization is required. For additional information please reference Hematopoietic Cell Transplantation from Chronic Myeloid Leukemia, MP-DE-1113
Hematopoietic Cell Transplantation for Solid Tumors of Childhood Surgery	**Codes**	**Prior Authorization Requirement**
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 Solid Tumors of Childhood Surgery, MP-DE-1118
Bone marrow harvesting for transplantation; allogeneic	38230	Prior authorization is required. For additional information please reference Hematopoietic Cell Transplantation for Solid Tumors of Childhood Surgery, MP-DE-1118
Bone marrow harvesting for transplantation; autologous	38232	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); 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); autologous transplantation	38241	Prior authorization is required. For additional information please reference Hematopoietic Cell Transplantation for Solid Tumors of Childhood Surgery, MP-DE-1118
Allogeneic lymphocyte infusions	38242	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; autologous	38206	Prior authorization is required. For additional information please reference Hematopoietic Cell Transplantation in Treatment of Germ-Cell Tumors, MP-DE-1119
Hematopoietic progenitor cell (HPC); allogeneic transplantation per donor	38240	Prior authorization is required. For additional information please reference Hematopoietic Cell 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 Waldenstrom Macroglobulinemia	**Codes**	**Prior Authorization Requirement**
Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; autologous	38206	Prior authorization is required. For additional information please reference Hematopoietic Cell Transplantation in Waldenstrom Macroglobulinemia, MP-DE-1121
Bone marrow harvesting for transplantation; allogeneic	38230	Prior authorization is required. For additional information please reference Hematopoietic Cell Transplantation in Waldenstrom Macroglobulinemia, MP-DE-1121
Bone marrow harvesting for transplantation; autologous	38232	Prior authorization is required. For additional information please reference Hematopoietic Cell 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); autologous transplantation	38241	Prior authorization is required. For additional information please reference Hematopoietic Cell Transplantation in Waldenstrom Macroglobulinemia, MP-DE-1121
Orthopedic Applications of Stem-Cell Therapy	**Codes**	**Prior Authorization Requirement**
Allograft, includes templating, cutting, placement and internal fixation, when performed; osteoarticular, including articular surface and contiguous bone (List separately in addition to code for primary procedure)	20932	Prior authorization is required. For additional information please reference Orthopedic Applications of Stem-Cell Therapy, MP-DE-1122
Allograft, includes templating, cutting, placement and internal fixation, when performed; hemicortical intercalary, partial (ie, hemicylindrical) (List separately in addition to code for primary procedure)	20933	Prior authorization is required. For additional information please reference Orthopedic Applications of Stem-Cell Therapy, MP-DE-1122
Allograft, includes templating, cutting, placement and internal fixation, when performed; intercalary, complete (ie, cylindrical) (List separately in addition to code for primary procedure)	20934	Prior authorization is required. For additional information please reference Orthopedic Applications of Stem-Cell Therapy, MP-DE-1122
Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; autologous	38206	Prior authorization is required. For additional information please reference Orthopedic Applications of Stem-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-Cell Therapy, MP-DE-1122
Bone marrow harvesting for transplantation; autologous	38232	Prior authorization is required. For additional information please reference Orthopedic Applications of Stem-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) placement, recording, analysis and interpretation	91034	Prior authorization is required. For additional information please reference Esophageal Ph Monitoring, MP-DE-1087
Esophagus, gastroesophageal reflux test; with mucosal attached telemetry pH electrode placement, recording, analysis and interpretation	91035	Prior authorization is required. For additional information please reference Esophageal Ph Monitoring, MP-DE-1087
Electroencephalogram (EEG) Technologies	**Codes**	**Prior Authorization Requirement**
Electroencephalogram (EEG) continuous recording, with video when performed, setup, patient education, and takedown when performed, administered in person by EEG technologist, minimum of 8 channels	95700	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; 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 monitoring and maintenance	95706	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 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; unmonitored	95708	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 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 hours, 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 (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 60 hours, up to 84 hours of EEG recording, with video (VEEG)	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 care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 84 hours of EEG recording, with video (VEEG)	95726	Prior authorization is required. For additional information please reference Electroencephalogram (EEG) Technologies, MP-DE-1088
Electroencephalogram (EEG) extended monitoring; 41-60 minutes	95812	Prior authorization is required. For additional information please reference Electroencephalogram (EEG) Technologies, MP-DE-1088
Electroencephalogram (EEG) extended monitoring; 61-119 minutes	95813	Prior authorization is required. For additional information please reference Electroencephalogram (EEG) Technologies, MP-DE-1088
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; initial hour of attendance by a physician or other qualified health care professional	95961	Prior authorization is required. For additional information please reference Electroencephalogram (EEG) Technologies, MP-DE-1088
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. For additional information please reference Electroencephalogram (EEG) Technologies, MP-DE-1088
Initiation of selective head or total body hypothermia in the critically ill neonate, 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	99184	Prior authorization is required. For additional information please reference Electroencephalogram (EEG) Technologies, MP-DE-1088
Electroencephalogram (EEG); including 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) Technologies, MP-DE-1088
Corneal Surgery to Correct Refractive Errors, Phototherapeutic Keratectomy and Corneal Collagen Cross-Linking Surgery	**Codes**	**Prior Authorization Requirement**
Collagen cross-linking of cornea, including removal of the corneal epithelium, when performed, and intraoperative pachymetry, when performed	0402T	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
Keratomileusis	65760	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 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**
Computed tomography, bone mineral density study, 1 or more sites, axial skeleton (eg, hips, pelvis, spine)	77078	Prior authorization is required. For additional information please reference Bone Mineral Density Studies, MP-DE-1105
Fetal Surgery for Prenatally Diagnosed Malformations	**Codes**	**Prior Authorization Requirement**
Fetal shunt placement, including ultrasound guidance	59076	Prior authorization is required. For additional information please reference Fetal Surgery for Prenatally Diagnosed Malformations, MP-DE-1110
Unlisted fetal invasive procedure, including ultrasound guidance, when performed	59897	Prior authorization is required. For additional information please reference Fetal Surgery for Prenatally Diagnosed Malformations, MP-DE-1110
Repair of sacrococcygeal teratoma in the fetus, procedure performed in utero	S2405	Prior authorization is required. For additional information please reference Fetal Surgery for Prenatally Diagnosed Malformations, MP-DE-1110
Urinary Incontinence Therapy	**Codes**	**Prior Authorization Requirement**
Unlisted procedure, urinary system	53899	Prior authorization is required. For additional information please reference Urinary Incontinence Therapy, MP-DE-1117
Fitting and insertion of pessary or other intravaginal support device	57160	Prior authorization is required. For additional information please reference Urinary Incontinence Therapy, MP-DE-1117
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. For additional information please reference Urinary Incontinence Therapy, MP-DE-1117
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. For additional information please reference Urinary Incontinence Therapy, MP-DE-1117
Application of a modality to 1 or more areas; electrical stimulation (manual), each 15 minutes	97032	Prior authorization is required. For additional information please reference Urinary Incontinence Therapy, MP-DE-1117
Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes	97530	Prior authorization is required. For additional information please reference Urinary Incontinence Therapy, MP-DE-1117
Transcatheter Aortic Valve Replacement	**Codes**	**Prior Authorization Requirement**
Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; percutaneous femoral artery approach	33361	Prior authorization is required. For additional information please reference Transcatheter Aortic Valve Replacement, MP-DE-1125
Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open femoral artery approach	33362	Prior authorization is required. For additional information please reference Transcatheter Aortic Valve Replacement, MP-DE-1125
Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open axillary artery approach	33363	Prior authorization is required. For additional information please reference Transcatheter Aortic Valve Replacement, MP-DE-1125
Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open iliac artery approach	33364	Prior authorization is required. For additional information please reference Transcatheter Aortic Valve Replacement, MP-DE-1125
Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transaortic approach (eg, median sternotomy, mediastinotomy)	33365	Prior authorization is required. For additional information please reference Transcatheter Aortic Valve Replacement, MP-DE-1125

Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transapical exposure (eg, left thoracotomy)	33366	Prior authorization is required. For additional information please reference Transcatheter Aortic Valve Replacement, MP-DE-1125
Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with percutaneous peripheral arterial and venous cannulation (eg, femoral vessels) (List separately in addition to code for primary procedure)	33367	Prior authorization is required. For additional information please reference Transcatheter Aortic Valve Replacement, MP-DE-1125
Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with open peripheral arterial and venous cannulation (eg, femoral, iliac, axillary vessels) (List separately in addition to code for primary procedure)	33368	Prior authorization is required. For additional information please reference Transcatheter Aortic Valve Replacement, MP-DE-1125
Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with central arterial and venous cannulation (eg, aorta, right atrium, pulmonary artery) (List separately in addition to code for primary procedure)	33369	Prior authorization is required. For additional information please reference Transcatheter Aortic Valve Replacement, MP-DE-1125
Transcatheter placement and subsequent removal of cerebral embolic protection device(s), including arterial access, catheterization, imaging, and radiological supervision and interpretation, percutaneous (List separately in addition to code for primary procedure)	33370	Prior authorization is required. For additional information please reference Transcatheter Aortic Valve Replacement, MP-DE-1125
Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, aortic valve	93591	Prior authorization is required. For additional information please reference Transcatheter Aortic Valve Replacement, MP-DE-1125
Transcatheter Mitral Valve Repair/Replacement	**Codes**	**Prior Authorization Requirement**
Transcatheter mitral valve repair, percutaneous approach, including transseptal puncture when performed; initial prosthesis	33418	Prior authorization is required. For additional information please reference Transcatheter Mitral Valve Repair/Replacement, MP-DE-1126
Transcatheter mitral valve repair, percutaneous approach, including transseptal puncture when performed; additional prosthesis(es) during same session (List separately in addition to code for primary procedure)	33419	Prior authorization is required. For additional information please reference Transcatheter Mitral Valve Repair/Replacement, MP-DE-1126
Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, mitral valve	93590	Prior authorization is required. For additional information please reference Transcatheter Mitral Valve Repair/Replacement, MP-DE-1126
Percutaneous transcatheter closure of paravalvular leak; each additional occlusion device (List separately in addition to code for primary procedure)	93592	Prior authorization is required. For additional information please reference Transcatheter Mitral Valve Repair/Replacement, MP-DE-1126
Electrical Bone Growth Stimulation Spinal	**Codes**	**Prior Authorization Requirement**
Electrical stimulation to aid bone healing; invasive (operative)	20975	Prior authorization is required. For additional information please reference Electrical Bone Growth Stimulation Spinal, MP-DE-1148
Osteogenesis stimulator, electrical, noninvasive, spinal applications	E0748	Prior authorization is required for billed charges greater than $500. For additional information please reference Electrical Bone Growth Stimulation Spinal, MP-DE-1148
Implantable Pulmonary Artery Pressure Measurement Device	**Codes**	**Prior Authorization Requirement**
Transcatheter implantation of wireless pulmonary artery pressure sensor for long-term hemodynamic monitoring, including deployment and calibration of the sensor, right heart catheterization, selective pulmonary catheterization, radiological supervision and interpretation, and pulmonary artery angiography, when performed	33289	Prior authorization is required. For additional information please reference Implantable Pulmonary Artery Pressure Measurement Device, MP-DE-1142
Remote monitoring of a wireless pulmonary artery pressure sensor for up to 30 days, including at least weekly downloads of pulmonary artery pressure recordings, interpretation(s), trend analysis, and report(s) by a physician or other qualified health care professional	93264	Prior authorization is required. For additional information please reference Implantable Pulmonary Artery Pressure Measurement Device, MP-DE-1142
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 cortical mapping, motor threshold determination, delivery and management	90867	Prior authorization is required. For additional information please reference Transcranial Magnetic Stimulation (TMS), MP-DE-1147
Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent delivery and management, per session	90868	Prior authorization is required. For additional information please reference Transcranial Magnetic Stimulation (TMS), MP-DE-1147
Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent motor threshold re-determination with delivery and management	90869	Prior authorization is required. For additional information please reference Transcranial Magnetic Stimulation (TMS), MP-DE-1147
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, noninvasive, other than spinal applications	E0747	Prior authorization is required when charges are greater than $500. For additional information please reference Non-Spinal Bone Growth Stimulation, MP-DE-1149
Cardiac Monitors	**Codes**	**Prior Authorization Requirement**
Insertion, subcutaneous cardiac rhythm monitor, including programming	33285	Prior authorization is required. For additional information please reference Cardiac Monitors, MP-DE-1152
Removal, subcutaneous cardiac rhythm monitor	33286	Prior authorization is required. For additional information please reference Cardiac Monitors, MP-DE-1152

External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; review and interpretation with report by a physician or other qualified health care professional	93228	Prior authorization is required. For additional information please reference Cardiac Monitors, MP-DE-1152
External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; technical support for connection and patient instructions for use, attended surveillance, analysis and transmission of daily and emergent data reports as prescribed by a physician or other qualified health care professional	93229	Prior authorization is required. For additional information please reference Cardiac Monitors, MP-DE-1152
External electrocardiographic recording for more than 48 hours up to 7 days by continuous rhythm recording and storage; recording (includes connection and initial recording)	93242	Prior authorization is required. For additional information please reference Cardiac Monitors, MP-DE-1152
External electrocardiographic recording for more than 48 hours up to 7 days by continuous rhythm recording and storage; scanning analysis with report	93243	Prior authorization is required. For additional information please reference Cardiac Monitors, MP-DE-1152
External electrocardiographic recording for more than 48 hours up to 7 days by continuous rhythm recording and storage; review and interpretation	93244	Prior authorization is required. For additional information please reference Cardiac Monitors, MP-DE-1152
External electrocardiographic recording for more than 7 days up to 15 days by continuous rhythm recording and storage; recording (includes connection and initial recording)	93246	Prior authorization is required. For additional information please reference Cardiac Monitors, MP-DE-1152
External electrocardiographic recording for more than 7 days up to 15 days by continuous rhythm recording and storage; review and interpretation	93248	Prior authorization is required. For additional information please reference Cardiac Monitors, MP-DE-1152
Interrogation device evaluation (in person) 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	93261	Prior authorization is required. For additional information please reference Cardiac Monitors, MP-DE-1152
External patient and, when performed, auto activated electrocardiographic rhythm derived 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	93268	Prior authorization is required. For additional information please reference Cardiac Monitors, MP-DE-1152
External patient and, when performed, auto 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)	93270	Prior authorization is required. For additional information please reference Cardiac Monitors, MP-DE-1152
External patient and, when performed, auto activated electrocardiographic rhythm derived event recording with symptom-related memory loop with remote download capability up to 30 days, 24-hour attended monitoring; transmission and analysis	93271	Prior authorization is required. For additional information please reference Cardiac Monitors, MP-DE-1152
External patient and, when performed, auto 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	93272	Prior authorization is required. For additional information please reference Cardiac Monitors, MP-DE-1152
Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; subcutaneous cardiac rhythm monitor system	93285	Prior authorization is required. For additional information please reference Cardiac Monitors, MP-DE-1152
Interrogation device evaluation (in person) with analysis, review and report by a 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	93291	Prior authorization is required. For additional information please reference Cardiac Monitors, MP-DE-1152
Interrogation device evaluation(s), (remote) 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	93297	Prior authorization is required. For additional information please reference Cardiac Monitors, MP-DE-1152
Interrogation device evaluation(s), (remote) up to 30 days; subcutaneous cardiac rhythm monitor system, including analysis of recorded heart rhythm data, analysis, review(s) and report(s) by a physician or other qualified health care professional	93298	Prior authorization is required. For additional information please reference Cardiac Monitors, MP-DE-1152
Bioengineered Skin	**Codes**	**Prior Authorization Requirement**
Tissue cultured skin autograft, trunk, arms, legs; first 25 sq cm or less	15150	Prior authorization is required. For additional information please reference Bioengineered Skin, MP-DE-1129
Tissue cultured skin autograft, trunk, arms, legs; additional 1 sq cm to 75 sq cm (List separately in addition to code for primary procedure)	15151	Prior authorization is required. For additional information please reference Bioengineered Skin, MP-DE-1129

Tissue cultured skin autograft, trunk, arms, legs; 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)	15152	Prior authorization is required. For additional information please reference Bioengineered Skin, MP-DE-1129
Tissue cultured skin autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 25 sq cm or less	15155	Prior authorization is required. For additional information please reference Bioengineered Skin, MP-DE-1129
Tissue cultured skin autograft, face, scalp, 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)	15156	Prior authorization is required. For additional information please reference Bioengineered Skin, MP-DE-1129
Tissue cultured skin autograft, face, scalp, 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)	15157	Prior authorization is required. For additional information please reference Bioengineered Skin, MP-DE-1129
Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area	15271	Prior authorization is required. For additional information please reference Bioengineered Skin, MP-DE-1129
Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (List separately in addition to code for primary procedure)	15272	Prior authorization is required. For additional information please reference Bioengineered Skin, MP-DE-1129
Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children	15273	Prior authorization is required. For additional information please reference Bioengineered Skin, MP-DE-1129
Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)	15274	Prior authorization is required. For additional information please reference Bioengineered Skin, MP-DE-1129
Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area	15275	Prior authorization is required. For additional information please reference Bioengineered Skin, MP-DE-1129
Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (List separately in addition to code for primary procedure)	15276	Prior authorization is required. For additional information please reference Bioengineered Skin, MP-DE-1129
Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children	15277	Prior authorization is required. For additional information please reference Bioengineered Skin, MP-DE-1129
Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)	15278	Prior authorization is required. For additional information please reference Bioengineered Skin, MP-DE-1129
Implantation of biologic implant (eg, acellular dermal matrix) for soft tissue reinforcement (ie, breast, trunk) (List separately in addition to code for primary procedure)	15777	Prior authorization is required. For additional information please reference Bioengineered Skin, MP-DE-1129
Tissue expander placement in breast reconstruction, including subsequent expansion(s)	19357	Prior authorization is required. For additional information please reference Bioengineered Skin, MP-DE-1129
Breast reconstruction; with latissimus dorsi flap	19361	Prior authorization is required. For additional information please reference Bioengineered Skin, MP-DE-1129
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 transverse rectus abdominis myocutaneous (TRAM) flap	19367	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, requiring separate microvascular anastomosis (supercharging)	19368	Prior authorization is required. For additional information please reference Bioengineered Skin, MP-DE-1129
Breast reconstruction; with bipedicled transverse rectus abdominis myocutaneous (TRAM) flap	19369	Prior authorization is required. For additional information please reference Bioengineered Skin, MP-DE-1129
Revision of reconstructed breast (eg, significant removal of tissue, re-advancement and/or re-inset of flaps in autologous reconstruction or significant capsular revision combined with soft tissue excision in implant-based reconstruction)	19380	Prior authorization is required. For additional information please reference Bioengineered Skin, MP-DE-1129
Portable External Infusion Pump	**Codes**	**Prior Authorization Requirement**
Chemotherapy administration, intravenous infusion technique; initiation of prolonged chemotherapy infusion (more than 8 hours), requiring use of a portable or implantable pump	96416	Prior authorization is required. For additional information please reference Portable External Infusion Pump, MP-DE-1134
Chemotherapy administration, intra-arterial; infusion technique, initiation of prolonged infusion (more than 8 hours), requiring the use of a portable or implantable pump	96425	Prior authorization is required. For additional information please reference Portable External Infusion Pump, MP-DE-1134
Refilling and maintenance of portable pump	96521	Prior authorization is required. For additional information please reference Portable External Infusion Pump, MP-DE-1134
Supplies for maintenance of noninsulin drug infusion catheter, per week (list drugs separately)	A4221	Prior authorization is required for billed charges greater than $500. For additional information please reference Portable External Infusion Pump, MP-DE-1134
Infusion supplies for external drug infusion pump, per cassette or bag (list drugs separately)	A4222	Prior authorization is required for billed charges greater than $500. For additional information please reference Portable External Infusion Pump, MP-DE-1134
Ambulatory infusion pump, mechanical, reusable, for infusion 8 hours or greater	E0779	Prior authorization is required for billed charges greater than $500. For additional information please reference Portable External Infusion Pump, MP-DE-1134
Ambulatory infusion pump, mechanical, reusable, for infusion less than 8 hours	E0780	Prior authorization is required for billed charges greater than $500. For additional information please reference Portable External Infusion Pump, MP-DE-1134

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	K0552	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, each	K0601	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, 3 volt, each	K0602	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, alkaline, 1.5 volt, each	K0603	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	K0604	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 iliac artery(ies) by deployment of an aorto-bi-iliac endograft 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 iliac 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 aortic bifurcation and distally to the iliac bifurcation, and treatment zone angioplasty/stenting, when performed, unilateral; for other than rupture (eg, for aneurysm, pseudoaneurysm, 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 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 aortic bifurcation and distally to the iliac bifurcation, and treatment zone angioplasty/stenting, when performed, unilateral; 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
Placement of extension prosthesis(es) distal to the common iliac artery(ies) or proximal to the renal artery(ies) for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, dissection, penetrating ulcer, 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 prosthesis 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 prosthesis 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; 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 supervision and interpretation	34712	Prior authorization is required. For additional information please reference Endovascular/Endoluminal Stent Grafts, MP-DE-1157
Percutaneous access and closure of femoral 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

Open axillary/subclavian artery exposure for delivery of endovascular prosthesis by infraclavicular or supraclavicular incision, unilateral (List separately in addition to code for primary procedure)	34715	Prior authorization is required. For additional information please reference Endovascular/Endoluminal Stent Grafts, MP-DE-1157
Open axillary/subclavian artery exposure with creation of conduit for delivery of endovascular prosthesis or for establishment of cardiopulmonary bypass, by infraclavicular or supraclavicular incision, unilateral (List separately in addition to code for primary procedure)	34716	Prior authorization is required. For additional information please reference Endovascular/Endoluminal Stent Grafts, MP-DE-1157
Endovascular placement of iliac artery occlusion device (List separately in addition to code for primary procedure)	34808	Prior authorization is required. For additional information please reference Endovascular/Endoluminal Stent Grafts, MP-DE-1157
Placement of femoral-femoral prosthetic graft during endovascular aortic aneurysm repair (List separately in addition to code for primary procedure)	34813	Prior authorization is required. For additional information please reference Endovascular/Endoluminal Stent Grafts, MP-DE-1157
Open repair of infrarenal aortic aneurysm or dissection, plus repair of associated arterial trauma, following unsuccessful endovascular repair; tube prosthesis	34830	Prior authorization is required. For additional information please reference Endovascular/Endoluminal Stent Grafts, MP-DE-1157
Open repair of infrarenal aortic aneurysm or dissection, plus repair of associated arterial trauma, following unsuccessful endovascular repair; aorto-bi-iliac prosthesis	34831	Prior authorization is required. For additional information please reference Endovascular/Endoluminal Stent Grafts, MP-DE-1157
Endovascular repair of visceral aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or 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)	34841	Prior authorization is required. For additional information please reference Endovascular/Endoluminal Stent Grafts, MP-DE-1157
Endovascular repair of visceral aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or 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])	34842	Prior authorization is required. For additional information please reference Endovascular/Endoluminal Stent Grafts, MP-DE-1157
Endovascular repair of visceral aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or 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])	34843	Prior authorization is required. For additional information please reference Endovascular/Endoluminal Stent Grafts, MP-DE-1157
Endovascular repair of visceral aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or 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])	34844	Prior authorization is required. For additional information please reference Endovascular/Endoluminal Stent Grafts, MP-DE-1157
Endovascular repair of visceral aorta and infrarenal abdominal aorta (eg, aneurysm, 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)	34845	Prior authorization is required. For additional information please reference Endovascular/Endoluminal Stent Grafts, MP-DE-1157
Endovascular repair of visceral aorta and infrarenal abdominal aorta (eg, aneurysm, 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 two visceral artery endoprostheses (superior mesenteric, celiac and/or renal artery[s])	34846	Prior authorization is required. For additional information please reference Endovascular/Endoluminal Stent Grafts, MP-DE-1157
Endovascular repair of visceral aorta and infrarenal abdominal aorta (eg, aneurysm, 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])	34847	Prior authorization is required. For additional information please reference Endovascular/Endoluminal Stent Grafts, MP-DE-1157
Endovascular repair of visceral aorta and infrarenal abdominal aorta (eg, aneurysm, 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 four or more visceral artery endoprostheses (superior mesenteric, celiac and/or renal artery[s])	34848	Prior authorization is required. For additional information please reference Endovascular/Endoluminal Stent Grafts, MP-DE-1157

Endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin	33880	Prior authorization is required. For additional information please reference Endovascular/Endoluminal Stent Grafts, MP-DE-1157
Endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); not involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin	33881	Prior authorization is required. For additional information please reference Endovascular/Endoluminal Stent Grafts, MP-DE-1157
Placement of proximal extension prosthesis for endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); initial extension	33883	Prior authorization is required. For additional information please reference Endovascular/Endoluminal Stent Grafts, MP-DE-1157
Placement of proximal extension prosthesis for endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); each additional proximal extension (List separately in addition to code for primary procedure)	33884	Prior authorization is required. For additional information please reference Endovascular/Endoluminal Stent Grafts, MP-DE-1157
Placement of distal extension prosthesis(s) delayed after endovascular repair of descending thoracic aorta	33886	Prior authorization is required. For additional information please reference Endovascular/Endoluminal Stent Grafts, MP-DE-1157
Open subclavian to carotid artery transposition performed in conjunction with endovascular repair of descending thoracic aorta, by neck incision, unilateral	33889	Prior authorization is required. For additional information please reference Endovascular/Endoluminal Stent Grafts, MP-DE-1157
Bypass graft, with other than vein, transcervical retropharyngeal carotid-carotid, performed in conjunction with endovascular repair of descending thoracic aorta, by neck incision	33891	Prior authorization is required. For additional information please reference Endovascular/Endoluminal Stent Grafts, MP-DE-1157
Unlisted procedure, vascular surgery	37799	Prior authorization is required. For additional information please reference Endovascular/Endoluminal Stent Grafts, MP-DE-1157
Endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin, radiological supervision and interpretation	75956	Prior authorization is required. For additional information please reference Endovascular/Endoluminal Stent Grafts, MP-DE-1157
Endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); not involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin, radiological supervision and interpretation	75957	Prior authorization is required. For additional information please reference Endovascular/Endoluminal Stent Grafts, MP-DE-1157
Placement of proximal extension prosthesis for endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption), radiological supervision and interpretation	75958	Prior authorization is required. For additional information please reference Endovascular/Endoluminal Stent Grafts, MP-DE-1157
Placement of distal extension prosthesis(s) (delayed) after endovascular repair of descending thoracic aorta, as needed, to level of celiac origin, radiological supervision and interpretation	75959	Prior authorization is required. For additional information please reference Endovascular/Endoluminal Stent Grafts, MP-DE-1157
Ultrasound, abdominal aorta, real time with image documentation, screening study for abdominal aortic aneurysm (AAA)	76706	Prior authorization is required. For additional information please reference Endovascular/Endoluminal Stent Grafts, MP-DE-1157
Corneal Transplantation	**Codes**	**Prior Authorization Requirement**
Keratoplasty (corneal transplant); anterior lamellar	65710	Prior authorization is required. For additional information please reference Corneal Transplantation, MP-DE-1221
Keratoplasty (corneal transplant); penetrating (except in aphakia or pseudophakia)	65730	Prior authorization is required. For additional information please reference Corneal Transplantation, MP-DE-1221
Keratoplasty (corneal transplant); penetrating (in aphakia)	65750	Prior authorization is required. For additional information please reference Corneal Transplantation, MP-DE-1221
Keratoplasty (corneal transplant); penetrating (in pseudophakia)	65755	Prior authorization is required. For additional information please reference Corneal Transplantation, MP-DE-1221
Keratoprosthesis	65770	Prior authorization is required. For additional information please reference Corneal Transplantation, MP-DE-1221
Artificial cornea	L8609	Prior authorization is required. For additional information please reference Corneal Transplantation, MP-DE-1221
Keratoplasty (corneal transplant); endothelial	65756	Prior authorization is required. For additional information please reference Corneal Transplantation, MP-DE-1221
Backbench preparation of corneal endothelial allograft prior to transplantation (List separately in addition to code for primary procedure)	65757	Prior authorization is required. For additional information please reference Corneal Transplantation, MP-DE-1221
Electroconvulsive Therapy	**Codes**	**Prior Authorization Requirement**
Electroconvulsive therapy (includes necessary monitoring)	90870	Prior authorization is required. For additional information please reference Electroconvulsive Therapy, MP-DE-1162
Anesthesia for electroconvulsive therapy	00104	Prior authorization is required. For additional information please reference Electroconvulsive Therapy, MP-DE-1162
Benign or Premalignant Skin Lesions	**Codes**	**Prior Authorization Requirement**
Removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions	11200	Prior authorization is required. For additional information please reference Removal of Benign or Premalignant Skin Lesions, MP-DE-1130
Removal of skin tags, multiple fibrocutaneous tags, any area; each additional 10 lesions, or part thereof (List separately in addition to code for primary procedure)	11201	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, trunk, arms or legs; lesion diameter 0.5 cm or less	11300	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, trunk, arms or legs; lesion diameter 0.6 to 1.0 cm	11301	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, trunk, arms or legs; lesion diameter 1.1 to 2.0 cm	11302	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, trunk, arms or legs; lesion diameter over 2.0 cm	11303	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, scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less	11305	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, scalp, neck, hands, feet, genitalia; lesion diameter 0.6 to 1.0 cm	11306	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, scalp, neck, hands, feet, genitalia; lesion diameter 1.1 to 2.0 cm	11307	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, 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
Shaving of epidermal or dermal lesion, single 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 Premalignant 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 or less	11440	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 0.6 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
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
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 code for first lesion)	17003	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), 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

Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; 15 or more lesions	17111	Prior authorization is required. For additional information please reference Removal of Benign or Premalignant Skin Lesions, MP-DE-1130
Responsive Neurostimulation for the Treatment of Refractory Partial Epilepsy	**Codes**	**Prior Authorization Requirement**
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 neurostimulator electrodes, cerebral, cortical	61860	Prior authorization is required. For additional information please reference Responsive Neurostimulation for the Treatment of Refractory Partial Epilepsy, MP-DE-1131
Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), without use of intraoperative microelectrode recording; first array	61863	Prior authorization is required. For additional information please reference Responsive Neurostimulation for the Treatment of Refractory Partial Epilepsy, MP-DE-1131
Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), without use of intraoperative microelectrode recording; each additional array (List separately in addition to primary procedure)	61864	Prior authorization is required. For additional information please reference Responsive Neurostimulation for the Treatment of Refractory Partial Epilepsy, MP-DE-1131
Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), with use of intraoperative microelectrode recording; first array	61867	Prior authorization is required. For additional information please reference Responsive Neurostimulation for the Treatment of Refractory Partial Epilepsy, MP-DE-1131
Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), with use of intraoperative microelectrode recording; each additional array (List separately in addition to primary procedure)	61868	Prior authorization is required. For additional information please reference Responsive Neurostimulation for the Treatment of Refractory Partial Epilepsy, MP-DE-1131
Revision or removal of intracranial 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 neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array	61885	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 neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to 2 or more electrode arrays	61886	Prior authorization is required. For additional information please reference Responsive Neurostimulation for the Treatment of Refractory Partial Epilepsy, MP-DE-1131
Revision or removal of cranial neurostimulator pulse generator or receiver	61888	Prior authorization is required. For additional information please reference Responsive Neurostimulation for the Treatment of Refractory Partial Epilepsy, MP-DE-1131
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, cranial nerve, spinal cord, peripheral nerve, or sacral nerve, neurostimulator pulse generator/transmitter, without programming	95970	Prior authorization is required. For additional information please reference Responsive Neurostimulation for the Treatment of Refractory Partial Epilepsy, MP-DE-1131
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 cranial nerve neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional	95976	Prior authorization is required. For additional information please reference Responsive Neurostimulation for the Treatment of Refractory Partial Epilepsy, MP-DE-1131
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 complex cranial nerve neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional	95977	Prior authorization is required. For additional information please reference Responsive Neurostimulation for the Treatment of Refractory Partial Epilepsy, MP-DE-1131
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-to-face time with physician or other qualified health care professional	95983	Prior authorization is required. For additional information please reference Responsive Neurostimulation for the Treatment of Refractory Partial Epilepsy, MP-DE-1131

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, 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. For additional information please reference Responsive Neurostimulation for the Treatment of Refractory Partial Epilepsy, MP-DE-1131
Transesophageal Endoscopic Therapies for Gastroesophageal Reflux Disease	**Codes**	**Prior Authorization Requirement**
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 substance	43201	Prior authorization is required. For additional information please reference Transesophageal Endoscopic Therapies for Gastroesophageal Reflux Disease, MP-DE-1139
Esophagogastroduodenoscopy, flexible, transoral; with esophagogastric fundoplasty, partial or complete, includes duodenoscopy when performed	43210	Prior authorization is required. For additional information please reference Transesophageal Endoscopic Therapies for Gastroesophageal Reflux Disease, MP-DE-1139
Esophagoscopy, flexible, transoral; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)	43212	Prior authorization is required. For additional information please reference Transesophageal Endoscopic Therapies for Gastroesophageal Reflux Disease, MP-DE-1139
Esophagogastroduodenoscopy, flexible, transoral; with directed submucosal injection(s), any substance	43236	Prior authorization is required. For additional information please reference Transesophageal Endoscopic Therapies for Gastroesophageal Reflux Disease, MP-DE-1139
Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-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)	43253	Prior authorization is required. For additional information please reference Transesophageal Endoscopic Therapies for Gastroesophageal Reflux Disease, MP-DE-1139
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 Transesophageal Endoscopic Therapies for Gastroesophageal Reflux Disease, MP-DE-1139
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 Transesophageal Endoscopic Therapies for Gastroesophageal Reflux Disease, MP-DE-1139
Unlisted procedure, esophagus	43499	Prior authorization is required. For additional information please reference Transesophageal Endoscopic Therapies for Gastroesophageal Reflux Disease, MP-DE-1139
Unlisted procedure, stomach	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**
Unlisted procedure, spine	22899	Prior authorization is required. For additional information please reference Interspinous and Interlaminar Stabilization/Distraction Devices, MP-DE-1155
Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level	22867	Prior authorization is required. For additional information please reference Interspinous and Interlaminar Stabilization/Distraction Devices, MP-DE-1155
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)	22868	Prior authorization is required. For additional information please reference Interspinous and Interlaminar Stabilization/Distraction Devices, MP-DE-1155
Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level	22869	Prior authorization is required. For additional information please reference Interspinous and Interlaminar Stabilization/Distraction Devices, MP-DE-1155
Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; second level (List separately in addition to code for primary procedure)	22870	Prior authorization is required. For additional information please reference Interspinous and Interlaminar Stabilization/Distraction Devices, MP-DE-1155
Treatment of Abnormal Uterine Bleeding and Fibroids	**Codes**	**Prior Authorization Requirement**
Magnetic resonance imaging guidance for, and monitoring of, parenchymal tissue ablation	77022	Prior authorization is required. For additional information please reference Treatment of Abnormal Uterine Bleeding and Fibroids, MP-DE-1156
Selective catheter placement, arterial system; each first order abdominal, pelvic, or lower extremity artery branch, within a vascular family	36245	Prior authorization is required. For additional information please reference Treatment of Abnormal Uterine Bleeding and Fibroids, MP-DE-1156
Selective catheter placement, arterial system; initial second order abdominal, pelvic, or lower extremity artery branch, within a vascular family	36246	Prior authorization is required. For additional information please reference Treatment of Abnormal Uterine Bleeding and Fibroids, MP-DE-1156
Selective catheter placement, arterial system; initial third order or more selective abdominal, pelvic, or lower extremity artery branch, within a vascular family	36247	Prior authorization is required. For additional information please reference Treatment of Abnormal Uterine Bleeding and Fibroids, MP-DE-1156
Selective catheter placement, arterial system; additional second order, third order, and beyond, abdominal, pelvic, or lower extremity artery branch, within a vascular family (List in addition to code for initial second or third order vessel as appropriate)	36248	Prior authorization is required. For additional information please reference Treatment of Abnormal Uterine Bleeding and Fibroids, MP-DE-1156
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 Abnormal Uterine Bleeding and Fibroids, MP-DE-1156
Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation	37244	Prior authorization is required. For additional information please reference Treatment of Abnormal Uterine Bleeding and Fibroids, MP-DE-1156

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, electrosurgical ablation, thermoablation)	58563	Prior authorization is required. For additional information please reference Treatment of Abnormal Uterine Bleeding and Fibroids, MP-DE-1156
Treatment of Prostate	**Codes**	**Prior Authorization Requirement**
Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; single implant	52441	Prior authorization is required. For additional information please reference Treatment of Prostate, MP-DE-1158
Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; each additional permanent adjustable transprostatic implant (List separately in addition to code for primary procedure)	52442	Prior authorization is required. For additional information please reference Treatment of Prostate, MP-DE-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, complete (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 control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included if performed)	52647	Prior authorization is required. For additional information please reference Treatment of Prostate, MP-DE-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; by microwave thermotherapy	53850	Prior authorization is required. For additional information please reference Treatment of Prostate, MP-DE-1158
Transurethral destruction of prostate tissue; by radiofrequency thermotherapy	53852	Prior authorization is required. For additional information please reference Treatment of Prostate, MP-DE-1158
Transurethral destruction of prostate tissue; by radiofrequency generated water vapor thermotherapy	53854	Prior authorization is required. For additional information please reference Treatment of Prostate, MP-DE-1158
Prostatectomy (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy); suprapubic, subtotal, 1 or 2 stages	55821	Prior authorization is required. For additional information please reference Treatment of Prostate, MP-DE-1158
Prostatectomy (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy); retropubic, subtotal	55831	Prior authorization is required. For additional information please reference Treatment of Prostate, MP-DE-1158
Prostatectomy, perineal, subtotal (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy)	55801	Prior authorization is required. For additional information please reference Treatment of Prostate, MP-DE-1158
Prostatectomy, perineal radical;	55810	Prior authorization is required. For additional information please reference Treatment of Prostate, MP-DE-1158
Prostatectomy, perineal radical; with lymph node biopsy(s) (limited pelvic lymphadenectomy)	55812	Prior authorization is required. For additional information please reference Treatment of Prostate, MP-DE-1158
Prostatectomy, perineal radical; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric and obturator nodes	55815	Prior authorization is required. For additional information please reference Treatment of Prostate, MP-DE-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 guidance	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	**Codes**	**Prior Authorization Requirement**
Operative ablation of supraventricular arrhythmogenic focus or pathway (eg, Wolff-Parkinson-White, atrioventricular node re-entry), tract(s) and/or focus (foci); without cardiopulmonary bypass	33250	Prior authorization is required. For additional information please reference Cardiac Ablation Procedure, MP-DE-1187

Operative ablation of supraventricular arrhythmogenic focus or pathway (eg, Wolff-Parkinson-White, atrioventricular node re-entry), tract(s) and/or focus (foci); with cardiopulmonary bypass	33251	Prior authorization is required. For additional information please reference Cardiac Ablation Procedure, MP-DE-1187
Operative tissue ablation and reconstruction of atria, limited (eg, modified maze procedure)	33254	Prior authorization is required. For additional information please reference Cardiac Ablation Procedure, MP-DE-1187
Operative tissue ablation and reconstruction of atria, extensive (eg, maze procedure); without cardiopulmonary bypass	33255	Prior authorization is required. For additional information please reference Cardiac Ablation Procedure, MP-DE-1187
Operative tissue ablation and reconstruction of atria, extensive (eg, maze procedure); with cardiopulmonary bypass	33256	Prior authorization is required. For additional information please reference Cardiac Ablation Procedure, MP-DE-1187
Operative tissue ablation and reconstruction of atria, performed at the time of other cardiac procedure(s), limited (eg, modified maze procedure) (List separately in addition to code for primary procedure)	33257	Prior authorization is required. For additional information please reference Cardiac Ablation Procedure, MP-DE-1187
Operative tissue ablation and reconstruction of atria, performed at the time of other cardiac procedure(s), extensive (eg, maze procedure), without cardiopulmonary bypass (List separately in addition to code for primary procedure)	33258	Prior authorization is required. For additional information please reference Cardiac Ablation Procedure, MP-DE-1187
Operative tissue ablation and reconstruction of atria, performed at the time of other cardiac procedure(s), extensive (eg, maze procedure), with cardiopulmonary bypass (List separately in addition to code for primary procedure)	33259	Prior authorization is required. For additional information please reference Cardiac Ablation Procedure, MP-DE-1187
Operative ablation of ventricular arrhythmogenic focus with cardiopulmonary bypass	33261	Prior authorization is required. For additional information please reference Cardiac Ablation Procedure, MP-DE-1187
Endoscopy, surgical; operative tissue ablation and reconstruction of atria, limited (eg, modified maze procedure), without cardiopulmonary bypass	33265	Prior authorization is required. For additional information please reference Cardiac Ablation Procedure, MP-DE-1187
Endoscopy, surgical; operative tissue ablation and reconstruction of atria, extensive (eg, maze procedure), without cardiopulmonary bypass	33266	Prior authorization is required. For additional information please reference Cardiac Ablation Procedure, MP-DE-1187
Intracardiac electrophysiologic 3-dimensional mapping (List separately in addition to code for primary procedure)	93613	Prior authorization is required. For additional information please reference Cardiac Ablation Procedure, MP-DE-1187
Intracardiac catheter ablation of atrioventricular node function, atrioventricular conduction for creation of complete heart block, with or without temporary pacemaker placement	93650	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 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	93653	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 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 ventricular tachycardia or focus of ventricular ectopy including left ventricular pacing and recording, when performed	93654	Prior authorization is required. For additional information please reference Cardiac Ablation Procedure, MP-DE-1187
Intracardiac catheter ablation of a discrete mechanism of arrhythmia which is distinct from the primary ablated mechanism, including repeat diagnostic maneuvers, to treat a spontaneous or induced arrhythmia (List separately in addition to code for primary procedure)	93655	Prior authorization is required. For additional information please reference Cardiac Ablation Procedure, MP-DE-1187
Comprehensive electrophysiologic evaluation including transseptal catheterizations, insertion and repositioning of multiple electrode catheters with intracardiac catheter ablation of atrial fibrillation by pulmonary vein isolation, including intracardiac electrophysiologic 3-dimensional mapping, intracardiac echocardiography including imaging supervision and interpretation, induction or attempted induction of an arrhythmia including left or right atrial pacing/recording, right ventricular pacing/recording, and His bundle recording, when performed	93656	Prior authorization is required. For additional information please reference Cardiac Ablation Procedure, MP-DE-1187
Additional linear or focal intracardiac catheter ablation of the left or right atrium for treatment of atrial fibrillation remaining after completion of pulmonary vein isolation (List separately in addition to code for primary procedure)	93657	Prior authorization is required. For additional information please reference Cardiac Ablation Procedure, MP-DE-1187
Intracardiac echocardiography during therapeutic/diagnostic intervention, including imaging supervision and interpretation (List separately in addition to code for primary procedure)	93662	Prior authorization is required. For additional information please reference Cardiac Ablation Procedure, MP-DE-1187
Amniotic Membrane and Amniotic Fluid	**Codes**	**Prior Authorization Requirement**
Matrion, per sq cm	Q4201	Prior authorization is required. For additional information please reference Amniotic Membrane and Amniotic Fluid, MP-DE-1194
XWRAP, per sq cm	Q4204	Prior authorization is required. For additional information please reference Amniotic Membrane and Amniotic Fluid, MP-DE-1194
Membrane Graft or Membrane Wrap, per sq cm	Q4205	Prior authorization is required. For additional information please reference Amniotic Membrane and Amniotic Fluid, MP-DE-1194

Novafix, per sq cm	Q4208	Prior authorization is required. For additional information please reference Amniotic Membrane and Amniotic Fluid, MP-DE-1194
SurGraft, per sq cm	Q4209	Prior authorization is required. For additional information please reference Amniotic Membrane and Amniotic Fluid, MP-DE-1194
Axolotl Graft or Axolotl DualGraft, per sq cm	Q4210	Prior authorization is required. For additional information please reference Amniotic Membrane and Amniotic Fluid, MP-DE-1194
Amnion Bio or AxoBioMembrane, per sq cm	Q4211	Prior authorization is required. For additional information please reference Amniotic Membrane and Amniotic Fluid, MP-DE-1194
Cellesta Cord, per sq cm	Q4214	Prior authorization is required. For additional information please reference Amniotic Membrane and Amniotic Fluid, MP-DE-1194
Artacent Cord, per sq cm	Q4216	Prior authorization is required. For additional information please reference Amniotic Membrane and Amniotic Fluid, MP-DE-1194
WoundFix, BioWound, WoundFix Plus, BioWound Plus, WoundFix Xplus or BioWound Xplus, per sq cm	Q4217	Prior authorization is required. For additional information please reference Amniotic Membrane and Amniotic Fluid, MP-DE-1194
SurgiCORD, per sq cm	Q4218	Prior authorization is required. For additional information please reference Amniotic Membrane and Amniotic Fluid, MP-DE-1194
SurgiGRAFT-DUAL, per sq cm	Q4219	Prior authorization is required. For additional information please reference Amniotic Membrane and Amniotic Fluid, MP-DE-1194
Amnio Wrap2, per sq cm	Q4221	Prior authorization is required. For additional information please reference Amniotic Membrane and Amniotic Fluid, MP-DE-1194
AmnioCoreTM, per sq cm	Q4227	Prior authorization is required. For additional information please reference Amniotic Membrane and Amniotic Fluid, MP-DE-1194
Cogenex Amniotic Membrane, per sq cm	Q4229	Prior authorization is required. For additional information please reference Amniotic Membrane and Amniotic Fluid, MP-DE-1194
Cogenex Flowable Amnion, per 0.5 cc	Q4230	Prior authorization is required. For additional information please reference Amniotic Membrane and Amniotic Fluid, MP-DE-1194
Corplex P, per cc	Q4231	Prior authorization is required. For additional information please reference Amniotic Membrane and Amniotic Fluid, MP-DE-1194
Corplex, per sq cm	Q4232	Prior authorization is required. For additional information please reference Amniotic Membrane and Amniotic Fluid, MP-DE-1194
SurFactor or NuDyn, per 0.5 cc	Q4233	Prior authorization is required. For additional information please reference Amniotic Membrane and Amniotic Fluid, MP-DE-1194
XCellerate, per sq cm	Q4234	Prior authorization is required. For additional information please reference Amniotic Membrane and Amniotic Fluid, MP-DE-1194
AMNIOREPAIR or AltiPly, per sq cm	Q4235	Prior authorization is required. For additional information please reference Amniotic Membrane and Amniotic Fluid, MP-DE-1194
Cryo-Cord, per sq cm	Q4237	Prior authorization is required. For additional information please reference Amniotic Membrane and Amniotic Fluid, MP-DE-1194
Amnio-Maxx or Amnio-Maxx Lite, per sq cm	Q4239	Prior authorization is required. For additional information please reference Amniotic Membrane and Amniotic Fluid, MP-DE-1194
CoreCyte, for topical use only, per 0.5 cc	Q4240	Prior authorization is required. For additional information please reference Amniotic Membrane and Amniotic Fluid, MP-DE-1194
PolyCyte, for topical use only, per 0.5 cc	Q4241	Prior authorization is required. For additional information please reference Amniotic Membrane and Amniotic Fluid, MP-DE-1194
AmnioCyte Plus, per 0.5 cc	Q4242	Prior authorization is required. For additional information please reference Amniotic Membrane and Amniotic Fluid, MP-DE-1194
Procenta, per 200 mg	Q4244	Prior authorization is required. For additional information please reference Amniotic Membrane and Amniotic Fluid, MP-DE-1194
AmnioText, per cc	Q4245	Prior authorization is required. For additional information please reference Amniotic Membrane and Amniotic Fluid, MP-DE-1194
CoreText or ProText, per cc	Q4246	Prior authorization is required. For additional information please reference Amniotic Membrane and Amniotic Fluid, MP-DE-1194
Amniotext patch, per sq cm	Q4247	Prior authorization is required. For additional information please reference Amniotic Membrane and Amniotic Fluid, MP-DE-1194
Dermacyte Amniotic Membrane Allograft, per sq cm	Q4248	Prior authorization is required. For additional information please reference Amniotic Membrane and Amniotic Fluid, MP-DE-1194
AMNIPLY, for topical use only, per sq cm	Q4249	Prior authorization is required. For additional information please reference Amniotic Membrane and Amniotic Fluid, MP-DE-1194
AmnioAmp-MP, per sq cm	Q4250	Prior authorization is required. For additional information please reference Amniotic Membrane and Amniotic Fluid, MP-DE-1194
Novafix DL, per sq cm	Q4254	Prior authorization is required. For additional information please reference Amniotic Membrane and Amniotic Fluid, MP-DE-1194
REGUaRD, for topical use only, per sq cm	Q4255	Prior authorization is required. For additional information please reference Amniotic Membrane and Amniotic Fluid, MP-DE-1194
Amniotic membrane for surgical reconstruction, per procedure	V2790	Prior authorization is required. For additional information please reference Amniotic Membrane and Amniotic Fluid, MP-DE-1194
Supervised Exercise Therapy for Peripheral Artery Disease	**Codes**	**Prior Authorization Requirement**
Peripheral arterial disease (PAD) rehabilitation, per session	93668	Prior authorization is required. For additional information please reference Supervised Exercise Therapy for Peripheral Artery Disease, MP-DE-1013
Temporomandibular Joint Dysfunction	**Codes**	**Prior Authorization Requirement**
Manipulation of temporomandibular joint(s) (TMJ), therapeutic, requiring an anesthesia service (ie, general or monitored anesthesia care)	21073	Prior authorization is required. For additional information please reference Temporomandibular Joint Dysfunction, MP-DE-1136
Closed treatment of temporomandibular dislocation; initial or subsequent	21480	Prior authorization is required. For additional information please reference Temporomandibular Joint Dysfunction, MP-DE-1136
Closed treatment of temporomandibular dislocation; complicated (eg, recurrent requiring intermaxillary fixation or splinting), initial or subsequent	21485	Prior authorization is required. For additional information please reference Temporomandibular Joint Dysfunction, MP-DE-1136
Open treatment of temporomandibular dislocation	21490	Prior authorization is required. For additional information please reference Temporomandibular Joint Dysfunction, 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
Arthroscopy, temporomandibular joint, surgical	29804	Prior authorization is required. For additional information please reference Temporomandibular Joint Dysfunction, MP-DE-1136
Injection(s), anesthetic agent(s) and/or steroid; trigeminal nerve, each branch (ie, ophthalmic, maxillary, mandibular)	64400	Prior authorization is required. For additional information please reference Temporomandibular Joint Dysfunction, MP-DE-1136
Temporomandibular joint arthrography, radiological supervision and interpretation	70332	Prior authorization is required. For additional information please reference Temporomandibular Joint Dysfunction, MP-DE-1136
Magnetic resonance (eg, proton) imaging, temporomandibular joint(s)	70336	Prior authorization is required. For additional information please reference Temporomandibular Joint Dysfunction, MP-DE-1136
Cephalogram, orthodontic	70350	Prior authorization is required. For additional information please reference Temporomandibular Joint Dysfunction, MP-DE-1136
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
Computed tomography, maxillofacial area; with contrast material(s)	70487	Prior authorization is required. For additional information please reference Temporomandibular Joint Dysfunction, MP-DE-1136
Computed tomography, maxillofacial area; without contrast material, followed by contrast material(s) and further sections	70488	Prior authorization is required. For additional information please reference Temporomandibular Joint Dysfunction, MP-DE-1136

Unlisted physical medicine/rehabilitation service or procedure	97799	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	78305	Prior authorization is required. For additional information please reference Temporomandibular Joint Dysfunction, MP-DE-1136
Needle electromyography; cranial nerve supplied muscle(s), unilateral	95867	Prior authorization is required. For additional information please reference Temporomandibular Joint Dysfunction, MP-DE-1136
Needle electromyography; cranial nerve supplied muscles, bilateral	95868	Prior authorization is required. For additional information please reference Temporomandibular Joint 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	**Codes**	**Prior Authorization Requirement**
Interrogation device evaluation (in person) 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	93292	Prior authorization is required. For additional information please reference Wearable Cardioverter-Defibrillator, MP-DE-1138
Initial set-up and programming by a physician or other qualified health care professional of wearable cardioverter-defibrillator 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	**Codes**	**Prior Authorization Requirement**
Heart-lung transplant with recipient cardiectomy-pneumonectomy	33935	Prior authorization is required. For additional information please reference Heart/Lung Transplant, MP-DE-1108
Intra-Arterial/Intravenous Therapeutic Procedures	**Codes**	**Prior Authorization Requirement**
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 outflow including the inferior or superior vena cava, fluoroscopic guidance, radiological supervision and interpretation and image documentation and report;	36901	Prior authorization is required. For additional information please reference Intra-Arterial/Intravenous Therapeutic Procedures, MP-DE-1109
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 outflow including the inferior or superior vena cava, fluoroscopic guidance, radiological supervision and interpretation and image documentation and report; with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty	36902	Prior authorization is required. For additional information please reference Intra-Arterial/Intravenous Therapeutic Procedures, MP-DE-1109
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 outflow including the inferior or superior vena cava, fluoroscopic guidance, radiological supervision and interpretation and image documentation and report; 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 segment	36903	Prior authorization is required. For additional information please reference Intra-Arterial/Intravenous Therapeutic Procedures, MP-DE-1109
Percutaneous transluminal mechanical thrombectomy 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 pharmacological thrombolytic injection(s);	36904	Prior authorization is required. For additional information please reference Intra-Arterial/Intravenous Therapeutic Procedures, MP-DE-1109

Percutaneous transluminal mechanical thrombectomy 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 pharmacological thrombolytic injection(s); with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty	36905	Prior authorization is required. For additional information please reference Intra-Arterial/Intravenous Therapeutic Procedures, MP-DE-1109
Percutaneous transluminal mechanical thrombectomy 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 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	36906	Prior authorization is required. For additional information please reference Intra-Arterial/Intravenous Therapeutic Procedures, MP-DE-1109
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 dialysis 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
Dialysis 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 performed;	37213	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 performed; cessation of thrombolysis including removal of catheter and vessel closure by any method	37214	Prior authorization is required. For additional information please reference Intra-Arterial/Intravenous Therapeutic Procedures, MP-DE-1109
Transcatheter placement of an intravascular 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 performed; initial artery	37236	Prior authorization is required. For additional information please reference Intra-Arterial/Intravenous Therapeutic Procedures, MP-DE-1109
Transcatheter placement of an intravascular 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 performed; each additional artery (List separately in addition to code for primary procedure)	37237	Prior authorization is required. For additional information please reference Intra-Arterial/Intravenous Therapeutic Procedures, MP-DE-1109
Transcatheter placement of an intravascular stent(s), open or percutaneous, including radiological supervision and interpretation and including angioplasty 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
Transcatheter placement of an intravascular stent(s), open or percutaneous, including radiological supervision and interpretation and including angioplasty within the same vessel, when performed; each additional vein (List separately in addition to code for primary procedure)	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(ies) 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 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; each additional artery (List separately in addition to code for primary procedure)	37247	Prior authorization is required. For additional information please reference Intra-Arterial/Intravenous Therapeutic Procedures, MP-DE-1109
Transluminal balloon angioplasty (except dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same vein; initial vein	37248	Prior authorization is required. For additional information please reference Intra-Arterial/Intravenous Therapeutic Procedures, MP-DE-1109
Transluminal balloon angioplasty (except dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same vein; each additional vein (List separately in addition to code for primary procedure)	37249	Prior authorization is required. For additional information please reference Intra-Arterial/Intravenous Therapeutic Procedures, MP-DE-1109
Percutaneous transluminal pulmonary artery 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 (List separately in addition to code for primary procedure)	92998	Prior authorization is required. For additional information please reference Intra-Arterial/Intravenous Therapeutic Procedures, MP-DE-1109
Catheter, transluminal angioplasty, nonlaser (may include guidance, infusion/perfusion capability)	C1725	Prior authorization is required. For additional information please reference Intra-Arterial/Intravenous Therapeutic Procedures, MP-DE-1109
Stent, coated/covered, with delivery system	C1874	Prior authorization is required. For additional information please reference Intra-Arterial/Intravenous Therapeutic Procedures, MP-DE-1109
Stent, noncoated/noncovered, with delivery system	C1876	Prior authorization is required. For additional information please reference Intra-Arterial/Intravenous Therapeutic Procedures, MP-DE-1109
Catheter, transluminal angioplasty, laser	C1885	Prior authorization is required. For additional information please reference Intra-Arterial/Intravenous Therapeutic Procedures, MP-DE-1109
Stent, noncoronary, temporary, with delivery system	C2625	Prior authorization is required. For additional information please reference Intra-Arterial/Intravenous Therapeutic Procedures, MP-DE-1109
Upper Gastrointestinal Endoscopy (EGD)	**Codes**	**Prior Authorization Requirement**
Esophagogastroduodenoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	43235	Prior authorization is required. For additional information please reference Upper Gastrointestinal Endoscopy (EGD), MP-DE-1217
Esophagogastroduodenoscopy, flexible, transoral; with directed submucosal injection(s), any substance	43236	Prior authorization is required. For additional information please reference Upper Gastrointestinal Endoscopy (EGD), MP-DE-1217
Esophagogastroduodenoscopy, flexible, transoral; with endoscopic ultrasound examination limited to the esophagus, stomach or duodenum, and adjacent structures	43237	Prior authorization is required. For additional information please reference Upper Gastrointestinal Endoscopy (EGD), MP-DE-1217
Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s), (includes endoscopic ultrasound examination limited to the esophagus, stomach or duodenum, and adjacent structures)	43238	Prior authorization is required. For additional information please reference Upper Gastrointestinal Endoscopy (EGD), MP-DE-1217
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, transoral; with transmural drainage of pseudocyst (includes placement of transmural drainage catheter[s]/stent[s], when performed, and endoscopic ultrasound, when performed)	43240	Prior authorization is required. For additional information please reference Upper Gastrointestinal Endoscopy (EGD), MP-DE-1217
Esophagogastroduodenoscopy, flexible, transoral; with insertion of intraluminal tube or catheter	43241	Prior authorization is required. For additional information please reference Upper Gastrointestinal Endoscopy (EGD), MP-DE-1217
Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-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)	43242	Prior authorization is required. For additional information please reference Upper Gastrointestinal Endoscopy (EGD), MP-DE-1217
Esophagogastroduodenoscopy, flexible, transoral; with injection sclerosis of esophageal/gastric varices	43243	Prior authorization is required. For additional information please reference Upper Gastrointestinal Endoscopy (EGD), MP-DE-1217
Esophagogastroduodenoscopy, flexible, transoral; with band ligation of esophageal/gastric varices	43244	Prior authorization is required. For additional information please reference Upper Gastrointestinal Endoscopy (EGD), MP-DE-1217
Esophagogastroduodenoscopy, flexible, transoral; with dilation of gastric/duodenal stricture(s) (eg, balloon, bougie)	43245	Prior authorization is required. For additional information please reference Upper Gastrointestinal Endoscopy (EGD), MP-DE-1217
Esophagogastroduodenoscopy, flexible, transoral; with directed placement of percutaneous gastrostomy tube	43246	Prior authorization is required. For additional information please reference Upper Gastrointestinal 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, transoral; with insertion of guide wire followed by passage of dilator(s) through esophagus over guide wire	43248	Prior authorization is required. For additional information please reference Upper Gastrointestinal Endoscopy (EGD), MP-DE-1217
Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic balloon dilation of esophagus (less than 30 mm diameter)	43249	Prior authorization is required. For additional information please reference Upper Gastrointestinal Endoscopy (EGD), MP-DE-1217
Esophagogastroduodenoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps	43250	Prior authorization is required. For additional information please reference Upper Gastrointestinal Endoscopy (EGD), MP-DE-1217
Esophagogastroduodenoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	43251	Prior authorization is required. For additional information please reference Upper Gastrointestinal Endoscopy (EGD), MP-DE-1217
Esophagogastroduodenoscopy, flexible, transoral; with optical endomicroscopy	43252	Prior authorization is required. For additional information please reference Upper Gastrointestinal Endoscopy (EGD), MP-DE-1217
Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-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)	43253	Prior authorization is required. For additional information please reference Upper Gastrointestinal Endoscopy (EGD), MP-DE-1217

Esophagogastroduodenoscopy, flexible, transoral; with endoscopic mucosal resection	43254	Prior authorization is required. For additional information please reference Upper Gastrointestinal 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	**Codes**	**Prior Authorization Requirement**
Arthroscopy, shoulder, surgical; with rotator cuff repair	29827	Prior authorization is required. For additional information please reference Anthrax Bovine Collagen, MP-DE-1223
Unlisted procedure, arthroscopy	29999	Prior authorization is required. For additional information please reference Anthrax Bovine Collagen, MP-DE-1223
BRCA1 & BRCA2 Genetic Mutation Testing and Related Genetic Counseling	**Codes**	**Prior Authorization Requirement**
BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis and full duplication/deletion analysis (ie, detection of large gene rearrangements)	81162	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 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 analysis; full sequence analysis	81165	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 analysis; full duplication/deletion analysis (ie, 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
BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; full duplication/deletion analysis (ie, detection of large gene rearrangements)	81167	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; 185delAG, 5385insC, 6174delT variants	81212	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 analysis; known familial variant	81215	Prior authorization is required. For additional information please reference BRCA1 & BRCA2 Genetic Mutation Testing and Related Genetic Counseling, MP-DE-1250

BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis	81216	Prior authorization is required. For additional information please reference BRCA1 & BRCA2 Genetic Mutation Testing and Related Genetic Counseling, MP-DE-1250
BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; known familial variant	81217	Prior authorization is required. For additional information please reference BRCA1 & BRCA2 Genetic 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	**Codes**	**Prior Authorization Requirement**
Low intensity ultrasound stimulation to aid bone healing, noninvasive (nonoperative)	20979	Prior authorization is required. For additional information please reference Ultrasound Osteogenesis Stimulator, MP-DE-1251
Coupling gel or paste, for use with ultrasound device, per oz	A4559	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**	**Prior Authorization Requirement**
Unlisted procedure, skin, mucous membrane and subcutaneous tissue	17999	Prior authorization is required. For additional information please reference Hyperhidrosis, MP-DE-1137
Thoracoscopy, surgical; with thoracic sympathectomy	32664	Prior authorization is required. For additional information please reference Hyperhidrosis, MP-DE-1137
Chemodenervation of eccrine glands; both axillae	64650	Prior authorization is required. For additional information please reference Hyperhidrosis, MP-DE-1137
Chemodenervation of eccrine glands; other area(s) (eg, scalp, face, neck), per day	64653	Prior authorization is required. For additional information please reference Hyperhidrosis, MP-DE-1137
Tympanic neurectomy	69676	Prior authorization is required. For additional information please reference Hyperhidrosis, MP-DE-1137
Application of a modality to 1 or more areas; iontophoresis, each 15 minutes	97033	Prior authorization is required. For additional information please reference Hyperhidrosis, MP-DE-1137
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	**Codes**	**Prior Authorization Requirement**
Unlisted neurological or neuromuscular diagnostic procedure	95999	Prior authorization is required. For additional information please reference Concussion Testing, MP-DE-1074
Psychological testing evaluation services by 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; first hour	96130	Prior authorization is required. For additional information please reference Concussion Testing, MP-DE-1074
Psychological testing evaluation services by 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)	96131	Prior authorization is required. For additional information please reference Concussion Testing, MP-DE-1074
Neuropsychological testing evaluation services by 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; first hour	96132	Prior authorization is required. For additional information please reference Concussion Testing, MP-DE-1074
Neuropsychological testing evaluation services by 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)	96133	Prior authorization is required. For additional information please reference Concussion Testing, MP-DE-1074
Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; first 30 minutes	96136	Prior authorization is required. For additional information please reference Concussion Testing, MP-DE-1074
Psychological or neuropsychological test administration and scoring by physician 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)	96137	Prior authorization is required. For additional information please reference Concussion Testing, MP-DE-1074
Psychological or neuropsychological test administration, with single automated, standardized instrument via electronic platform, with automated result only	96146	Prior authorization is required. For additional information please reference Concussion Testing, MP-DE-1074
Anesthesia Provided in Conjuction with Non-Covered Procedures	**Codes**	**Prior Authorization Requirement**
Anesthesia for intraoral procedures, including biopsy	00170	Prior authorization is required. For additional information please reference Anesthesia Provided in 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 subsequent 15-minute increment.	D9223	Prior authorization is required. For additional information please reference Anesthesia Provided in Conjuction with Non-Covered Procedures, MP-DE-1075
for intravenous moderate (conscious) sedation/analgesia, initial 15 minutes.	D9239	Prior authorization is required. For additional information please reference Anesthesia Provided in Conjuction with Non-Covered Procedures, MP-DE-1075
Intravenous moderate (conscious) sedation/analgesia – each subsequent 15-minute increment.	D9243	Prior authorization is required. For additional information please reference Anesthesia Provided in Conjuction with Non-Covered Procedures, MP-DE-1075
Non-IV Conscious Sedation: Moderate sedation using pills or intramuscular injection.	D9248	Prior authorization is required. For additional information please reference Anesthesia Provided in Conjuction with Non-Covered Procedures, MP-DE-1075
Rhinomanometry	**Codes**	**Prior Authorization Requirement**
Nasal Function Studies,Eg, Rhinomanometry	92512	Prior authorization is required. For additional information please reference Rhinomanometry, MP-DE-1179.
Negative Pressure Wound Therapy	**Codes**	**Prior Authorization Requirement**
Negative pressure wound therapy (eg, vacuum assisted drainage collection), utilizing durable medical equipment (DME), 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	97605	Prior authorization is required. Please refer to Negative Pressure Wound Therapy, MP-DE-1039 for additional requirements.

Negative pressure wound therapy (eg, vacuum assisted drainage collection), utilizing durable medical equipment (DME), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters	97606	Prior authorization is required. Please refer to Negative Pressure Wound Therapy, MP-DE-1039 for additional requirements.
Wound care set, for negative pressure wound therapy electrical pump, includes all supplies and accessories	A6550	For billed charges greater than $500, prior authorization is required. Please refer to Negative Pressure Wound Therapy, MP-DE-1039 for additional requirements.
Canister, disposable, used with suction pump, each	A7000	For billed charges greater than $500, prior authorization is required. Please refer to Negative Pressure Wound Therapy, MP-DE-1039 for additional requirements.
Canister, nondisposable, used with suction pump, each	A7001	For billed charges greater than $500, prior authorization is required. Please refer to Negative Pressure Wound Therapy, MP-DE-1039 for additional requirements.
Negative pressure wound therapy electrical pump, stationary or portable	E2402	For billed charges greater than $500, prior authorization is required. Please refer to Negative Pressure Wound Therapy, MP-DE-1039 for additional requirements.
Vision Therapy	**Codes**	**Prior Authorization Requirement**
Orthoptic training; performed by a physician or other qualified health care professional	92065	Prior authorization is required. For additional information please refer to Vision Therapy, MP-DE-1228.
Electromagnetic Navigational Bronchoscopy	**Codes**	**Prior Authorization Requirement**
Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of fiducial markers, single or multiple	31626	Prior authorization is required. For additional information please refer to Electromagnetic Navigational Bronchoscopy, MP-DE-1230
Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with computer-assisted, image-guided navigation (List separately in addition to code for primary procedure[s])	31627	Prior authorization is required. For additional information please refer to Electromagnetic Navigational Bronchoscopy, MP-DE-1230
Posterior Tibial Nerve Stimulation	**Codes**	**Prior Authorization Requirement**
Posterior tibial neurostimulation, percutaneous needle electrode, single treatment, includes programming	64566	Prior authorization is required. For additional information please refer to Posterior Tibial Nerve Stimulation, MP-DE-1237
Electrical Nerve Stimulation	**Codes**	**Prior Authorization Requirement**
Open implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve)	64575	Prior authorization is required. For additional information please refer to Electrical Nerve Stimulation, MP-DE-1238
Open implantation of neurostimulator electrode array; neuromuscular	64580	Prior authorization is required. For additional information please refer to Electrical Nerve Stimulation, MP-DE-1238
Revision or removal of peripheral neurostimulator electrode array	64585	Prior authorization is required. For additional information please refer to Electrical Nerve Stimulation, MP-DE-1238
Percutaneous implantation of neurostimulator electrode array; cranial nerve	64553	Prior authorization is required. For additional information please refer to Electrical Nerve Stimulation, MP-DE-1238
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 cranial nerve neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional	95976	Prior authorization is required. For additional information please refer to Electrical Nerve Stimulation, MP-DE-1238
Radiofrequency Ablation of Miscellaneous Solid Tumors	**Codes**	**Prior Authorization Requirement**
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.
Laparoscopy, surgical; ablation of renal mass lesion(s), including intraoperative ultrasound guidance and monitoring, when performed	50542	Prior authorization is required. Please refer to Radiofrequency Ablation of Miscellaneous Solid Tumors, MP-DE-1218 for additional requirements.
Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy	50593	Prior authorization is required. Please refer to Radiofrequency Ablation of Miscellaneous Solid Tumors, MP-DE-1218 for additional requirements.
Ablation, 1 or more renal tumor(s), percutaneous, unilateral, radiofrequency	50592	Prior authorization is required. Please refer to Radiofrequency Ablation of Miscellaneous Solid Tumors, MP-DE-1218 for additional requirements.
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)	31641	Prior authorization is required. Please refer to Radiofrequency Ablation of Miscellaneous Solid 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; cryoablation	32994	Prior authorization is required. Please refer to Radiofrequency Ablation of Miscellaneous Solid Tumors, MP-DE-1218 for additional requirements.
Ablation therapy for reduction or eradication of 1 or more bone tumors (eg, metastasis) including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed; cryoablation	20983	Prior authorization is required. Please refer to Radiofrequency Ablation of Miscellaneous Solid Tumors, MP-DE-1218 for additional requirements.
Ablation, cryosurgical, of fibroadenoma, including ultrasound guidance, each fibroadenoma	19105	Prior authorization is required. Please refer to Radiofrequency Ablation of Miscellaneous Solid Tumors, MP-DE-1218 for additional requirements.
Noninvasive Assessment of Liver Fibrosis in Chronic Hepatitis	**Codes**	**Prior Authorization Requirement**
Liver elastography, mechanically induced shear wave (eg, vibration), without imaging, with interpretation and report	91200	Prior authorization is required. For additional information please refer to Noninvasive Assessment of Liver Fibrosis in Chronic Hepatitis, MP-DE-1014
Ultrasound Guidance for Joint, Tendon, Tendon Sheath, and Trigger Point Injections	**Codes**	**Prior Authorization Requirement**
Arthrocentesis, aspiration and/or injection, small joint or bursa (e.g., fingers, toes); without ultrasound guidance	20600	Prior authorization is required. For additional information please refer to Ultrasound Guidance for Joint, Tendon, Tendon Sheath, and Trigger Point Injections, MP-DE-1253
Arthrocentesis, aspiration and/or injection, small joint or bursa (e.g., fingers, toes); with ultrasound guidance, with permanent recording and reporting	20604	Prior authorization is required. For additional information please refer to Ultrasound Guidance for Joint, Tendon, Tendon Sheath, and Trigger Point Injections, MP-DE-1253
Arthrocentesis, aspiration and/or injection; intermediate joint or bursa (e.g., temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa); without ultrasound guidance	20605	Prior authorization is required. For additional information please refer to Ultrasound Guidance for Joint, Tendon, Tendon Sheath, and Trigger Point Injections, MP-DE-1253

Arthrocentesis, aspiration and/or injection; intermediate joint or bursa (e.g., temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa); with ultrasound guidance, with permanent recording and reporting	20606	Prior authorization is required. For additional information please refer to Ultrasound Guidance for Joint, Tendon, Tendon Sheath, and Trigger Point Injections, MP-DE-1253
Arthrocentesis, aspiration and/or injection; major joint or bursa (e.g., shoulder, hip, knee joint, subacromial bursa); without ultrasound guidance	20610	Prior authorization is required. For additional information please refer to Ultrasound Guidance for Joint, Tendon, Tendon Sheath, and Trigger Point Injections, MP-DE-1253
Arthrocentesis, aspiration and/or injection; major joint or bursa (e.g., shoulder, hip, knee joint, subacromial bursa); with ultrasound guidance, with permanent recording and reporting	20611	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 tendon sheath, or ligament, aponeurosis (e.g., plantar "fascia"	20550	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 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 point(s), 1 or 2 muscle(s)	20552	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 point(s), 3 or more muscle(s)	20553	Prior authorization is required. For additional information please refer to Ultrasound Guidance for Joint, Tendon, Tendon Sheath, and Trigger Point Injections, MP-DE-1253
Ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), imaging supervision and interpretation	76942	Prior authorization is required. For additional information please refer to Ultrasound Guidance for Joint, Tendon, Tendon Sheath, and Trigger Point Injections, MP-DE-1253
Ultrasound, extremity, nonvascular, real-time with image documentation; limited, anatomic specific	76882	Prior authorization is required. For additional information please refer to Ultrasound Guidance for Joint, Tendon, Tendon Sheath, and Trigger Point Injections, MP-DE-1253
DME Policies	**Codes**	**Prior Authorization Requirement**
Myolectric Upper Extremity Orthoses	L6026, L6704,L6715, L6880, L6890, L6895,L6925,L6930,L6935,L6945, L6955,L6965,L6965, L6975,L7007, L7008, L7009, L7045, L7180, L7181,L7190,L7191	For billed charges greater than $500, prior authorization is required. Please refer to Myolectric Upper Extremity Orthoses, MP-DE-1031 for additional requirements.
Home Oxygen Therapy	A4606 A4608 A4615 A4616 A4617 A4619 A4620 E0424 E0425 E0430 E0431 E0433 E0434 E0435 E0439 E0440 E0441 E0442 E0443 E0445 E0447 E0455 E0550 E0555 E0560 E0585 E1352	For billed charges greater than $500, prior authorization is required. Please refer to Home Oxygen Therapy, MP-DE-1030 for additional requirements.
High Frequency Chest Wall Oscillation Devices	A7020 A7025 A7026 E0482 E0483	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.
Pneumatic Compression Devices	E0650 E0651 E0652 E0655 E0657 E0660 E0665 E0666 E0667 E0668 E0669 E0670 E0675 E0676 E1399	For billed charges greater than $500, prior authorization is required. Please refer to Pneumatic Compression Devices, MP-DE-1144 for additional requirements.

Coverage for Hearing Aids	V5030 V5040 V5050 V5060 V5070 V5080 V5090 V5095 V5100 V5120 V5130 V5140 V5150 V5171 V5172 V5181 V5190 V5230 V5242 V5243 V5244 V5245 V5246 V5247 V5248 V5249 V5250	For billed charges greater than $500, prior authorization is required. Please refer to Coverage for Hearing Aids, MP-DE-1140 for additional requirements.
Beds, Accessories and Related Items	E0250 E0251 E0255 E0256 E0290 E0291 E0292 E0293 E0294 E0295 E0296 E0297 E0260 E0261 E0265 E0266 E0193 E0194 E0300 E0328 E0329 E0301 E0302 E0303 E0304 E0184 E0185	For billed charges greater than $500, prior authorization is required. Please refer to Beds, Accessories and Related Items, MP-DE-1183 for additional requirements.
External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing	V5030 V5040 V5050 V5060 V5070 V5080 V5100 V5120 V5130 V5140 V5150 V5171 V5172 V5181 V5211 V5212 V5213 V5214 V5215 V5221 V5230 V5242 V5243 V5244 V5245 V5246 V5247	For billed charges greater than $500, 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.
Functional Neuromuscular Electrical Stimulation and Other Electrical Stimulator	A4595 E0745 E0764 E0770	For billed charges greater than $500, prior authorization is required. Please refer to Functional Neuromuscular Electrical Stimulation and Other Electrical Stimulator, MP-DE-1185 for additional requirements.
Home Apnea Monitors	E0618, E0619, E1933	For billed charges greater than $500, prior authorization is required. Please refer to Home Apnea Monitors, MP-DE-1069 for additional requirements.
Home Dialysis Equipment and Supplies	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	For billed charges greater than $500, prior authorization is required. Please refer to Home Dialysis Equipment and Supplies, MP-DE-1070 for additional requirements.
Speech Generating Devices	E1902, E2500, E2502, E2504, E2506, E2508, E2510, E2511, E2512, E2599	For billed charges greater than $500, prior authorization is required. Please refer to Speech Generating Devices, MP-DE-1077 for additional requirements.
Oxygen	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	For billed charges greater than $500, prior authorization is required. Please refer to Oxygen, MP-DE-1072 for additional requirements.
Tumor Treatment fields	E0766	For billed charges greater than $500, prior authorization is required. Please refer to Tumor Treatment fields, MP-DE-1244 for additional requirements.
Home Cervical Traction therapy	E0840, E0849, E0850, E0855, E0860	For billed charges greater than $500, prior authorization is required. Please refer to Oxygen, MP-DE-1072 for additional requirements.

Enteral Feeding In-Line Catridge (EFIC)	B4105	For billed charges greater than $500, prior authorization is required. Please refer to Enteral Feeding In-Line Cartridge, MP-DE-1010 for additional requirements.
Transcutaneous Transducer Garments	E0731	For billed charges greater than $500, prior authorization is required. Please refer to Transcutaneous Transducer Garments, MP-DE-1247 for additional requirements.
Home Pulse Oximetry Devices	E0445, A4606	For billed charges greater than $500, prior authorization is required. Please refer to Home Pulse Oximetry Devices, MP-DE-1079 for additional requirements.
Devices used for the Treatment of Obstructive Sleep Apnea in Adults	E0601, E0470, E0471, E0485, E0486, A4604, A7002, A7027, A7028, A7029, A7030, A7033, A7034, A7035, A7036, A7037, A7038, A7039, A7044, A7045, A7046, A7047, E0561, E0562, E0600	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.
Respiratory Assist Devices	A4604, A7027, A7028, A7029, A7030, A7031, A7032, A7033, A7034, A7035, A7036, A7037, A7038, A7039, A7044, A7045, A7046, E0470, E0471, E0472, E0561, E0562	For billed charges greater than $500, prior authorization is required. Please refer to Respiratory Assist Devices, MP-DE-1076 for additional requirements.
Attendant Care Services	**Codes**	**Prior Authorization Requirement**
Attendant care services; per 15 minutes	S5125	Prior authorization is required. Coverage is limited to DSHP+ LTSS members.
Cognitive Assessment and Therapy	**Codes**	**Prior Authorization Requirement**
Policy Forthcoming		
Chore Services	**Codes**	**Prior Authorization Requirement**
Chore services; per 15 minutes	S5120	Prior authorization is required. Coverage is limited to DSHP+ LTSS members.
Home Delivered Meals	**Codes**	**Prior Authorization Requirement**
Home delivered meals, including preparation; per meal (fresh)	S5170	Prior authorization is required. Coverage is limited to two meals per day for DSHP+ LTSS members.
Home delivered meals, including preparation; per meal (frozen)	S5170-U1	Prior authorization is required. Coverage is limited to two meals per day for DSHP+ LTSS members.
Home delivered meals, including preparation; per meal (emergency meal)	S5170-ET	Prior authorization is required. Coverage is limited to two meals per day for DSHP+ LTSS members.
Minor Home Modifications	**Codes**	**Prior Authorization Requirement**
Home modifications; per service	S5165	Prior authorization is required. Coverage is limited to DSHP+ LTSS members who do not reside in an assisted living or nursing facility.
Nutritional Supplements for individuals diagnosed with HIV/AIDS	**Codes**	**Prior Authorization Requirement**
Dialysis/stress vitamin supplement, oral, 100 capsules	S0194	Prior authorization is required. Coverage is limited to DSHP+ LTSS members who have been diagnosed with HIV/AIDS (B20, B97.35, Z21)
Personal Emergency Response Systems (PERS)	**Codes**	**Prior Authorization Requirement**
Emergency response system; installation and testing	S5160	Prior authorization is required. Coverage is limited to DSHP+ LTSS members who do not reside in an assisted living or nursing facility.
Emergency response system; service fee, per month (excludes installation and testing)	S5161	Prior authorization is required. Coverage is limited to DSHP+ LTSS members who do not reside in an assisted living or nursing facility.
Emergency response system; purchase only	S5162	Prior authorization is required. Coverage is limited to DSHP+ LTSS members who do not reside in an assisted living or nursing facility.
Respite Care-Outpatient	**Codes**	**Prior Authorization Requirement**
Unskilled respite care, not hospice; per 15 minutes	S5150	Prior authorization is required. Coverage is limited to DSHP+ LTSS members.
Respite Care-Inpatient	**Codes**	**Prior Authorization Requirement**
Unskilled respite care, not hospice; per diem	S5151	Prior authorization is required. Coverage is limited to DSHP+ LTSS members.
Self-Directed Attendant Care	**Codes**	**Prior Authorization Requirement**
Self-Directed Attendant Care Services, per 15 minutes	S5130	Prior authorization is required. Coverage is limited to DSHP+ LTSS members.
Workshops and Transition Services for those moving from a nursing facility to the community	**Codes**	**Prior Authorization Requirement**
Community transition, waiver; per service	T2038	Prior authorization is required. Coverage is limited to DSHP+ LTSS members. There is a financial limit of $2,500.00 per transition, this may be used for covering housing application fees security deposit, utilities home furnishings and household essentials including food supplies. This assistance can be provided through connecting the member to community resources or directly by the Contractor. These items are not billed directly to HHO, the Nursing Facility Transition CM utilizes an expense card.
Adult Day Services	**Codes**	**Prior Authorization Requirement**
Day care services, adult; per half day	S5101	Prior authorization is required. Coverage is limited to DSHP+ LTSS members who do not reside in a assisted living or nursing facility. Meals are not seperately reimbursable.
Day care services, adult; per half day-Enhanced Services	S5101-U1	Prior authorization is required. Coverage is limited to DSHP+ LTSS members who do not reside in a assisted living or nursing facility. Meals are not seperately reimbursable.
Day care services, center-based; services not included in program fee, per diem	S5105	Prior authorization is required. Coverage is limited to DSHP+ LTSS members who do not reside in a assisted living or nursing facility. Meals are not seperately reimbursable.
Day care services, center-based; services not included in program fee, per diem-Enhanced Services	S5105-U1	Prior authorization is required. Coverage is limited to DSHP+ LTSS members who do not reside in a assisted living or nursing facility. Meals are not seperately reimbursable.
Day Habilitation	**Codes**	**Prior Authorization Requirement**
Day habilitation, waiver; per diem	T2020	Prior authorization is required. Coverage is limited to DSHP+ LTSS members. Not available to members living in non-ABI assisted living and nursing facilities.
Assisted Living	**Codes**	**Prior Authorization Requirement**
All Inclusive Rate-All-inclusive room and board plus ancillary	0100	Prior authorization is required. Coverage is limited to LTSS members.
All Inclusive Rate-All-inclusive room and board	0101	Prior authorization is required. Coverage is limited to LTSS members.
Custodial Care	**Codes**	**Prior Authorization Requirement**
All Inclusive Rate-All-inclusive room and board plus ancillary	0100	Prior authorization is required. Coverage is limited to LTSS members.
All Inclusive Rate-All-inclusive room and board	0101	Prior authorization is required. Coverage is limited to LTSS members.
Room & Board-Semiprivate (Two-Beds)-Other	0129	Prior authorization is required. Coverage is limited to LTSS members.
Subacute Care-Other Subacute Care	0199	Prior authorization is required. Coverage is limited to LTSS members.
Hospice Service-Hospice Room & Board-Nursing Facility	0658	Prior authorization is required. Coverage is limited to LTSS members.
Cardiology-Radiology	**Codes**	**Prior Authorization Requirement**
Transcatheter insertion or replacement of permanent leadless pacemaker, right ventricular, including imaging guidance (eg, fluoroscopy, venous ultrasound, ventriculography, femoral venography) and device evaluation (eg, interrogation or programming), when performed	33274	Prior Authorization goes through eviCore
Transcatheter implantation of wireless pulmonary artery pressure sensor (CardioMEMS™) for long-term hemodynamic monitoring, including deployment and calibration of the sensor, right heart catheterization, selective pulmonary catheterization, radiological supervision and interpretation, and pulmonary artery angiography, when performed	33289	Prior Authorization goes through eviCore
M R I T M J	70336	Prior Authorization goes through eviCore

C T Head Without Contrast	70450	Prior Authorization goes through eviCore
C T Head With Contrast	70460	Prior Authorization goes through eviCore
C T Head Without & With Contrast	70470	Prior Authorization goes through eviCore
C T Orbit Without Contrast	70480	Prior Authorization goes through eviCore
C T Orbit With Contrast	70481	Prior Authorization goes through eviCore
C T Orbit Without & With Contrast	70482	Prior Authorization goes through eviCore
C T Maxillofacial Without Contrast	70486	Prior Authorization goes through eviCore
C T Maxillofacial With Contrast	70487	Prior Authorization goes through eviCore
C T Maxillofacial Without & With Contrast	70488	Prior Authorization goes through eviCore
C T Soft Tissue Neck Without Contrast	70490	Prior Authorization goes through eviCore
C T Soft Tissue Neck With Contrast	70491	Prior Authorization goes through eviCore
C T Soft Tissue Neck Without & With Contrast	70492	Prior Authorization goes through eviCore
C T Angiography Head	70496	Prior Authorization goes through eviCore
C T Angiography Neck	70498	Prior Authorization goes through eviCore
M R I Orbit, Face, and/or Neck Without Contrast	70540	Prior Authorization goes through eviCore
M R I Face, Orbit, and/or Neck With Contrast	70542	Prior Authorization goes through eviCore
M R I Face, Orbit, and/or Neck With & Without Contrast	70543	Prior Authorization goes through eviCore
M R A Head Without Contrast	70544	Prior Authorization goes through eviCore
M R A Head With Contrast	70545	Prior Authorization goes through eviCore
M R A 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 physician	70555	Prior Authorization goes through eviCore
C T Thorax Without Contrast	71250	Prior Authorization goes through eviCore
C T Thorax With Contrast	71260	Prior Authorization goes through eviCore
C T Thorax Without & With Contrast	71270	Prior Authorization goes through eviCore
C T Angiography Chest Without Contrast Material, Followed by Contrast Material and Further Sections,Including Image Postprocessing	71275	Prior Authorization goes through eviCore
M R I Chest Without Contrast	71550	Prior Authorization goes through eviCore
M R I Chest With Contrast	71551	Prior Authorization goes through eviCore
M R I Chest With & Without Contrast	71552	Prior Authorization goes through eviCore
M R A Chest (Excluding Myocardium) With Or Without Contrast	71555	Prior Authorization goes through eviCore
C T Cervical Spine Without Contrast	72125	Prior Authorization goes through eviCore
C T Cervical Spine With Contrast	72126	Prior Authorization goes through eviCore
C T Cervical Spine Without & With Contrast	72127	Prior Authorization goes through eviCore
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 Contrast	72130	Prior Authorization goes through eviCore
C T Lumbar Spine Without Contrast	72131	Prior Authorization goes through eviCore
C T Lumbar Spine With Contrast	72132	Prior Authorization goes through eviCore
C T Lumbar Spine Without & With Contrast	72133	Prior Authorization goes through eviCore
M R I Cervical Spine Without Contrast	72141	Prior Authorization goes through eviCore
M R I Cervical Spine With Contrast	72142	Prior Authorization goes through eviCore
M R I Thoracic Spine Without Contrast	72146	Prior Authorization goes through eviCore
M R I Thoracic Spine With Contrast	72147	Prior Authorization goes through eviCore
M R I Lumbar Spine Without Contrast	72148	Prior Authorization goes through eviCore
M R I Lumbar Spine With Contrast	72149	Prior Authorization goes through eviCore
M R I Cervical Spine With & Without Contrast	72156	Prior Authorization goes through eviCore
M R I Thoracic Spine With & Without Contrast	72157	Prior Authorization goes through eviCore
M R I Lumbar Spine With & Without Contrast	72158	Prior Authorization goes through eviCore
M R A Spinal Canal With Or Without Contrast	72159	Prior Authorization goes through eviCore
C T Angiography Pelvis	72191	Prior Authorization goes through eviCore
C T Pelvis Without Contrast	72192	Prior Authorization goes through eviCore
C T Pelvis With Contrast	72193	Prior Authorization goes through eviCore
C T Pelvis Without & With Contrast	72194	Prior Authorization goes through eviCore
M R I Pelvis Without Contrast	72195	Prior Authorization goes through eviCore
M R I Pelvis With Contrast	72196	Prior Authorization goes through eviCore
M R I Pelvis With & Without Contrast	72197	Prior Authorization goes through eviCore
M R A Pelvis With Or Without Contrast	72198	Prior Authorization goes through eviCore
C T Upper Extremity Without Contrast	73200	Prior Authorization goes through eviCore
C T Upper Extremity With Contrast	73201	Prior Authorization goes through eviCore
C T Upper Extremity Without & With Contrast	73202	Prior Authorization goes through eviCore
C T Angiography Upper Extremity	73206	Prior Authorization goes through eviCore
M R I Upper Extremity Without Contrast	73218	Prior Authorization goes through eviCore
M R I Upper Extremity With Contrast	73219	Prior Authorization goes through eviCore
M R I Upper Extremity With & Without Contrast	73220	Prior Authorization goes through eviCore
M R I Upper Extremity Joint Without Contrast	73221	Prior Authorization goes through eviCore
M R I Upper Extremity Joint With Contrast	73222	Prior Authorization goes through eviCore
M R I Upper Extremity Joint With & Without Contrast	73223	Prior Authorization goes through eviCore
M R A Upper Extremity With Or Without Contrast	73225	Prior Authorization goes through eviCore
C T Lower Extremity Without Contrast	73700	Prior Authorization goes through eviCore
C T Lower Extremity With Contrast	73701	Prior Authorization goes through eviCore
C T Lower Extremity Without & With Contrast	73702	Prior Authorization goes through eviCore

C T Angiography Lower Extremity	73706	Prior Authorization goes through eviCore
M R I Lower Extremity Without Contrast	73718	Prior Authorization goes through eviCore
M R I Lower Extremity With Contrast	73719	Prior Authorization goes through eviCore
M R I Lower Extremity With & Without Contrast	73720	Prior Authorization goes through eviCore
M R I Lower Extremity Joint Without Contrast	73721	Prior Authorization goes through eviCore
M R I Lower Extremity Joint With Contrast	73722	Prior Authorization goes through eviCore
M R I Lower Extremity Joint With & Without Contrast	73723	Prior Authorization goes through eviCore
M R A Lower Extremity With Or Without Contrast	73725	Prior Authorization goes through eviCore
C T Abdomen Without Contrast	74150	Prior Authorization goes through eviCore
C T Abdomen With Contrast	74160	Prior Authorization goes through eviCore
C T Abdomen Without & With Contrast	74170	Prior Authorization goes through eviCore
CT angiography, abdomen and pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing	74174	Prior Authorization goes through eviCore
C T Angiography Abdomen	74175	Prior Authorization goes through eviCore
CT Abdomen And Pelvis Without Contrast	74176	Prior Authorization goes through eviCore
CT Abdomen And Pelvis With Contrast	74177	Prior Authorization goes through eviCore
Computed Tomography, Abdomen And Pelvis; Without Contrast Material In One Or Both Body Regions, Followed By Contrast Material(S) And Further Sections In One Or Both Body Regions	74178	Prior Authorization goes through eviCore
M R I Abdomen Without Contrast	74181	Prior Authorization goes through eviCore
M R I Abdomen With Contrast	74182	Prior Authorization goes through eviCore
M R I Abdomen With & Without Contrast	74183	Prior Authorization goes through eviCore
M R A Abdomen With Or Without Contrast	74185	Prior Authorization goes through eviCore
Computed tomographic (CT) colonography, diagnostic, including image postprocessing; without contrast material	74261	Prior Authorization goes through eviCore
Computed tomographic (CT) colonography, diagnostic, including image postprocessing; with contrast material(s) including non-contrast images, if performed	74262	Prior Authorization goes through eviCore
Computed tomographic (CT) colonography, screening, including image postprocessing	74263	Prior Authorization goes through eviCore
Magnetic resonance (eg, proton) imaging, fetal, including placental and maternal pelvic imaging when performed; single or first gestation	74712	Prior Authorization goes through eviCore
Cardiac magnetic resonance imaging for morphology and function without contrast material	75557	Prior Authorization goes through eviCore
Cardiac magnetic resonance imaging for morphology and function without contrast material; with stress imaging	75559	Prior Authorization goes through eviCore
Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences	75561	Prior Authorization goes through eviCore
Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences; with stress imaging	75563	Prior Authorization goes through eviCore
Cardiac magnetic resonance imaging for velocity flow mapping (list separately in addition to code for primary procedure)	75565	Prior Authorization goes through eviCore
Computed tomography, heart, without contrast material, with quantitative evaluation of coronary calcium	75571	Prior Authorization goes through eviCore
Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology (including 3d image postprocessing, assessment of cardiac function, and evaluation of venous structures, if performed)	75572	Prior Authorization goes through eviCore
Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology in the setting of congenital heart disease (including 3D image postprocessing, assessment of left ventricular [LV] cardiac function, right ventricular [RV] structure and function and evaluation of vascular structures, if performed)	75573	Prior Authorization goes through eviCore
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)	75574	Prior Authorization goes through eviCore
C T Angiography Abdominal Aorta	75635	Prior Authorization goes through eviCore
3D Rendering W/O Postprocessing	76376	Prior Authorization goes through eviCore
3D Rendering W Postprocessing	76377	Prior Authorization goes through eviCore

C T Limited Or Localized Follow-Up Study	76380	Prior Authorization goes through eviCore
M R I Spectroscopy	76390	Prior Authorization goes through eviCore
Magnetic resonance (eg, vibration) elastography	76391	Prior Authorization goes through eviCore
M R I Guidance For Needle Placement	77021	Prior Authorization goes through eviCore
Magnetic resonance guidance for, and monitoring of, parenchymal tissue ablation	77022	Prior Authorization goes through eviCore
Magnetic resonance imaging, breast, without contrast material; unilateral	77046	Prior Authorization goes through eviCore
Magnetic resonance imaging, breast, without contrast material; bilateral	77047	Prior Authorization goes through eviCore
Magnetic resonance imaging, breast, without and with contrast material(s), including computer-aided detection (CAD real-time lesion detection, characterization and pharmacokinetic analysis), when performed; unilateral	77048	Prior Authorization goes through eviCore
Magnetic resonance imaging, breast, without and with contrast material(s), including computer-aided detection (CAD real-time lesion detection, characterization and pharmacokinetic analysis), when performed; bilateral	77049	Prior Authorization goes through eviCore
Computed Tomography, bone mineral density study, 1 or more sites; axial skeleton	77078	Prior Authorization goes through eviCore
Magnetic resonance (eg, proton) imaging, bone marrow blood supply	77084	Prior Authorization goes through eviCore
Thyroid uptake, single or multiple quantitative measurement(s) (including stimulation, suppression, or discharge, when performed)	78012	Prior Authorization goes through eviCore
Thyroid imaging (including vascular flow, when performed)	78013	Prior Authorization goes through eviCore
Thyroid imaging (including vascular flow, when performed); with single or multiple uptake(s) quantitative measurement(s) (including stimulation, suppression, or discharge, when performed)	78014	Prior Authorization goes through eviCore
Thyroid Met Imaging	78015	Prior Authorization goes through eviCore
Thyroid Met Imaging With Additional Studies	78016	Prior Authorization goes through eviCore
Thyroid Scan Whole Body	78018	Prior Authorization goes through eviCore
Thyroid Carcinoma Metastases Uptake	78020	Prior Authorization goes through eviCore
Parathyroid planar imaging (including subtraction, when performed)	78070	Prior Authorization goes through eviCore
Parathyroid planar imaging (including subtraction, when performed); with tomographic (SPECT)	78071	Prior Authorization goes through eviCore
Parathyroid planar imaging (including subtraction, when performed); with tomographic (SPECT), and concurrently acquired computed tomography (CT) for anatomical localization	78072	Prior Authorization goes through eviCore
Adrenal Nuclear Imaging	78075	Prior Authorization goes through eviCore
Bone Marrow Imaging, Limited	78102	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 Flow	78185	Prior Authorization goes through eviCore
Lymph System Imaging	78195	Prior Authorization goes through eviCore
Liver Imaging	78201	Prior Authorization goes through eviCore
Liver Imaging With Flow	78202	Prior Authorization goes through eviCore
Liver & Spleen Imaging	78215	Prior Authorization goes through eviCore
Liver & Spleen Imaging With Flow	78216	Prior Authorization goes through eviCore
Hepatobiliary system imaging, including gallbladder when present;	78226	Prior Authorization goes through eviCore
Hepatobiliary system imaging, including gallbladder when present; with pharmacologic intervention, including quantitative measurement(s) when performed	78227	Prior Authorization goes through eviCore
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
Gastroesophageal Reflux Exam	78262	Prior Authorization goes through eviCore
Gastric Emptying Study	78264	Prior Authorization goes through eviCore
Gastric emptying imaging study (eg, solid, liquid, or both); with small bowel transit	78265	Prior Authorization goes through eviCore
Gastric emptying imaging study (eg, solid, liquid, or both); with small bowel and colon transit, multiple days	78266	Prior Authorization goes through eviCore
GI Bleeder Scan	78278	Prior Authorization goes through eviCore
Meckels Diverticulum Imaging	78290	Prior Authorization goes through eviCore
Leveen Shunt Patency Exam	78291	Prior Authorization goes through eviCore
Bone Or Joint Imaging Limited	78300	Prior Authorization goes through eviCore
Bone Or Joint Imaging Multiple	78305	Prior Authorization goes through eviCore
Bone Scan Whole Body	78306	Prior Authorization goes through eviCore
Bone Scan 3 Phase Study	78315	Prior Authorization goes through eviCore
Non-Imaging Heart Function	78414	Prior Authorization goes through eviCore
Cardiac Shunt Imaging	78428	Prior Authorization goes through eviCore

Myocardial imaging, positron emission 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	78429	Prior Authorization goes through eviCore
Myocardial imaging, positron emission tomography (PET), perfusion study (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	78430	Prior Authorization goes through eviCore
Myocardial imaging, positron emission 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	78431	Prior Authorization goes through eviCore
Myocardial imaging, positron emission 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);	78432	Prior Authorization goes through eviCore
Myocardial imaging, positron emission 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); with concurrently acquired computed tomography transmission scan	78433	Prior Authorization goes through eviCore
Absolute quantitation of myocardial blood flow (AQMBF), positron emission tomography (PET), rest and pharmacologic stress (List separately in addition to code for primary procedure)	78434	Prior Authorization goes through eviCore
Radionuclide Venogram Non-Cardiac	78445	Prior Authorization goes through eviCore
78451 myocardial perfusion imaging, 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)	78451	Prior Authorization goes through eviCore
Myocardial perfusion imaging, tomographic (spect) (including attenuation correction, 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	78452	Prior Authorization goes through eviCore
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)	78453	Prior Authorization goes through eviCore
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	78454	Prior Authorization goes through eviCore
Acute Venous Thrombosis Imaging	78456	Prior Authorization goes through eviCore
Venous Thrombosis Imaging Unilateral	78457	Prior Authorization goes through eviCore
Venous Thrombosis Images, Bilateral	78458	Prior Authorization goes through eviCore
Myocardial imaging, positron emission tomography (PET), metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), single study	78459	Prior Authorization goes through eviCore
Myocardial Infarction Scan	78466	Prior Authorization goes through eviCore
Heart Infarct Image Ejection Fraction	78468	Prior Authorization goes through eviCore
Heart Infarct Image 3D SPECT	78469	Prior Authorization goes through eviCore
Cardiac Bloodpool Img, Single	78472	Prior Authorization goes through eviCore
Cardiac Bloodpool Img, Multi	78473	Prior Authorization goes through eviCore
Heart First Pass Single	78481	Prior Authorization goes through eviCore
Cardiac Blood Pool Imaging -- Multiple	78483	Prior Authorization goes through eviCore
Myocardial imaging, positron emission tomography (PET), perfusion study(including ventricular wall motion[s] and/or ejection fraction[s], when performed); single study, at rest or stress (exercise or pharmacologic)	78491	Prior Authorization goes through eviCore

Myocardial imaging, positron emission tomography (PET), perfusion study(including ventricular wall motion[s] and/or ejection fraction[s], when performed); multiple studies at rest and/or stress (exercise or pharmacologic)	78492	Prior Authorization goes through eviCore
Cardiac Blood Pool Imaging , SPECT	78494	Prior Authorization goes through eviCore
Cardiac blood pool imaging, gated equilibrium, single study, at rest, with right ventricular ejection fraction by first pass technique (List separately in addition to code for primary procedure)	78496	Prior Authorization goes through eviCore
Pulmonary ventilation imaging (eg, aerosol or gas)	78579	Prior Authorization goes through eviCore
Pulmonary perfusion imaging (eg, particulate)	78580	Prior Authorization goes through eviCore
Pulmonary ventilation (eg, aerosol or gas) and perfusion imaging	78582	Prior Authorization goes through eviCore
Quantitative differential pulmonary perfusion, including imaging when performed	78597	Prior Authorization goes through eviCore
Quantitative differential pulmonary perfusion and ventilation (eg, aerosol or gas), including imaging when performed	78598	Prior Authorization goes through eviCore
Brain Imaging Limited Static	78600	Prior Authorization goes through eviCore
Brain Limited Imaging And Flow	78601	Prior Authorization goes through eviCore
Brain Imaging Complete	78605	Prior Authorization goes through eviCore
Brain Imaging Complete With Flow	78606	Prior Authorization goes through eviCore
Brain Flow Imaging Only	78610	Prior Authorization goes through eviCore
Cisternogram (Cerebrospinal Fluid Flow)	78630	Prior Authorization goes through eviCore
Cerebrospinal Ventriculography	78635	Prior Authorization goes through eviCore
CSF Shunt Evaluation	78645	Prior Authorization goes through eviCore
C S F Leakage Detection And Localization	78650	Prior Authorization goes through eviCore
Radiopharmaceutical Dacryocystography	78660	Prior Authorization goes through eviCore
Unlisted Nuclear Medicine Procedures on the Nervous System	78699	Prior Authorization goes through eviCore
Kidney Imaging Morphology	78700	Prior Authorization goes through eviCore
Kidney Imaging With Vascular Flow	78701	Prior Authorization goes through eviCore
Kidney Imaging With Vascular Flow & Function Single Study Without Pharmacological Intervention	78707	Prior Authorization goes through eviCore
Kidney Imaging Single Study With Pharmacological Intervention	78708	Prior Authorization goes through eviCore
Kidney Imaging - Multiple Studies Without & With Pharmacological Intervention	78709	Prior Authorization goes through eviCore
Kidney Function Study - Non-Imaging Radioisotopic	78725	Prior Authorization goes through eviCore
Urinary Bladder Residual Study	78730	Prior Authorization goes through eviCore
Ureteral Reflux Study	78740	Prior Authorization goes through eviCore
Testicular Imaging With Vascular Flow	78761	Prior Authorization goes through eviCore
Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); planar, single limited area (includes vascular flow and blood pool imaging, when performed); planar, single (includes vascular flow and blood pool imaging, when performed); planar, single	78800	Prior Authorization goes through eviCore
Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); planar, 2 or more mulitple areas (eg, abdomen and pelvis, head and chest), 1 or more days imaging or single area imaging over 2 or more days	78801	Prior Authorization goes through eviCore
Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); planar, whole body, single day imaging	78802	Prior Authorization goes through eviCore
Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); tomographic (SPECT) , single area (eg, head, neck, chest, pelvis), single day imaging	78803	Prior Authorization goes through eviCore
Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); planar, whole body, requiring 2 or more days imaging	78804	Prior Authorization goes through eviCore

Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); tomographic (SPECT) with concurrently acquired computed tomography (CT) transmission scan for anatomical review, localization and determination/detection of pathology, single area (eg, head, neck, chest, pelvis), single day imaging	78830	Prior Authorization goes through eviCore
Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); tomographic (SPECT), minimum 2 areas (eg, pelvis and knees, abdomen and pelvis), single day imaging, or single area imaging over 2 or more days	78831	Prior Authorization goes through eviCore
Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); tomographic (SPECT) with concurrently acquired computed tomography (CT) transmission scan for anatomical review, localization and determination/detection of pathology, minimum 2 areas (eg, pelvis and knees, abdomen and pelvis), single day imaging, or single area imaging over 2 or more days	78832	Prior Authorization goes through eviCore
Unlisted procedure, diagnostic nuclear medicine-radiation therapy treatment planning	78999	Prior Authorization goes through eviCore
Transthoracic echocardiography for congenital cardiac anomalies; complete	93303	Prior Authorization goes through eviCore
Transthoracic echocardiography for congenital cardiac anomalies; follow-up or limited study	93304	Prior Authorization goes through eviCore
Echocardiography, transthoracic, real-time with image documentation (2d), includes m-mode recording, when performed, complete, with spectral doppler echocardiography, and with color flow doppler echocardiography	93306	Prior Authorization goes through eviCore
Echocardiography, transthoracic, real-time with image documentation (2d) with or without m-mode recording; complete	93307	Prior Authorization goes through eviCore
Echocardiography, transthoracic, real-time with image documentation (2d) with or without m-mode recording; follow-up or limited study	93308	Prior Authorization goes through eviCore
TEE 2D;Incl Probe Placement, Imaging/Interp/Report	93312	Prior Authorization goes through eviCore
Echocardiography, transesophageal, real-time with image documentation (2D) (with or without M-mode recording); placement of transesophageal probe only	93313	Prior Authorization goes through eviCore
Echocardiography, transesophageal, real-time with image documentation (2D) (with or without M-mode recording); image acquisition, interpretation and report only	93314	Prior Authorization goes through eviCore
Transesophageal echocardiography for congenital cardiac anomalies; including probe placement, image acquisition, interpretation and report	93315	Prior Authorization goes through eviCore
Transesophageal echocardiography for congenital cardiac anomalies; placement of transesophageal probe only	93316	Prior Authorization goes through eviCore
Transesophageal echocardiography for congenital cardiac anomalies; image acquisition, interpretation and report only	93317	Prior Authorization goes through eviCore
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	93319	Prior Authorization goes through eviCore
Doppler echocardiography, pulsed wave and/or continuous wave with spectral display; complete	93320	Prior Authorization goes through eviCore
Doppler echocardiography, pulsed wave and/or continuous wave with spectral display; follow-up or limited study	93321	Prior Authorization goes through eviCore
Doppler echocardiography color flow velocity mapping	93325	Prior Authorization goes through eviCore

Echocardiography, transthoracic, real-time with image documentation (2d), with or without m-mode recording, during rest and cardiovascular stress test, with interpretation and report	93350	Prior Authorization goes through eviCore
Echocardiography, transthoracic, 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	93351	Prior Authorization goes through eviCore
Use of echocardiographic contrast agent during stress echocardiography (list separately in addition to code for primary procedure)	93352	Prior Authorization goes through eviCore
Myocardial strain imaging using speckle tracking-derived assessment of myocardial mechanics (List separately in addition to codes for echocardiography imaging)	93356	Prior Authorization goes through eviCore
Right Heart Catheterization Including Measurement(S) Of Oxygen Saturation And Cardiac Output, When Performed	93451	Prior Authorization goes through eviCore
Left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed	93452	Prior Authorization goes through eviCore
Combined right and left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed	93453	Prior Authorization goes through eviCore
Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation	93454	Prior Authorization goes through eviCore
Catheter placement in coronary artery(s) 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	93455	Prior Authorization goes through eviCore
Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right heart catheterization	93456	Prior Authorization goes through eviCore
Catheter placement in coronary artery(s) 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	93457	Prior Authorization goes through eviCore
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	93458	Prior Authorization goes through eviCore
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	93459	Prior Authorization goes through eviCore
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 injection(s) for left ventriculography, when performed	93460	Prior Authorization goes through eviCore

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 injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography	93461	Prior Authorization goes through eviCore
Left heart catheterization by transseptal puncture through intact septum or by transapical puncture (list separately in addition to code for primary procedure)	93462	Prior Authorization goes through eviCore
Right heart catheterization for congenital heart defect(s) including imaging guidance by the proceduralist to advance the catheter to the target zone; normal native connections	93593	Prior Authorization goes through eviCore
Right heart catheterization for congenital heart defect(s) including imaging guidance by the proceduralist to advance the catheter to the target zone; abnormal native connections	93594	Prior Authorization goes through eviCore
Left heart catheterization for congenital heart defect(s) including imaging guidance by the proceduralist to advance the catheter to the target zone, normal or abnormal native connections	93595	Prior Authorization goes through eviCore
Right and left heart catheterization for congenital heart defect(s) including imaging guidance by the proceduralist to advance the catheter to the target zone(s); normal native connections	93596	Prior Authorization goes through eviCore
Right and left heart catheterization for congenital heart defect(s) including imaging guidance by the proceduralist to advance the catheter to the target zone(s); connections abnormal native connections	93597	Prior Authorization goes through eviCore
CT Perfusion Brain	0042T	Prior Authorization goes through eviCore
Myocardial sympathetic innervation imaging, planar qualitative and quantitative assessment;	0331T	Prior Authorization goes through eviCore
Myocardial sympathetic innervation imaging, planar qualitative and quantitative assessment; with tomographic SPECT	0332T	Prior Authorization goes through eviCore
Myocardial contrast perfusion echocardiography, at rest or with stress, for assessment of myocardial ischemia or viability (List separately in addition to code for primary procedure)	0439T	Prior Authorization goes through eviCore
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 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 discordant data, interpretation and report	0501T	Prior Authorization goes through eviCore
data preparation and transmission	0502T	Prior Authorization goes through eviCore
analysis of fluid dynamics and simulated maximal coronary hyperemia, and generation of estimated FFR model	0503T	Prior Authorization goes through eviCore
anatomical data review in comparison with estimated FFR model to reconcile discordant data, interpretation and report	0504T	Prior Authorization goes through eviCore
Insertion of wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming, and imaging supervision and interpretation, when performed; complete system (includes electrode and generator [transmitter and battery])	0515T	Prior Authorization goes through eviCore
Insertion of wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming, and imaging supervision and interpretation, when performed; electrode only	0516T	Prior Authorization goes through eviCore
Insertion of wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming, and imaging supervision and interpretation, when performed; pulse generator component(s) (battery and/or transmitter) only	0517T	Prior Authorization goes through eviCore

Removal and replacement of wireless cardiac stimulator for left ventricular pacing; pulse generator component(s) (battery and/or transmitter)	0519T	Prior Authorization goes through eviCore
Removal and replacement of wireless cardiac stimulator for left ventricular pacing; pulse generator component(s) (battery and/or transmitter), including placement of a new electrode	0520T	Prior Authorization goes through eviCore
Insertion or replacement of implantable cardioverter-defibrillator system with 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	0571T	Prior Authorization goes through eviCore
Insertion of substernal implantable defibrillator electrode	0572T	Prior Authorization goes through eviCore
Magnetic resonance spectroscopy, 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	0609T *	Prior Authorization goes through eviCore
Magnetic resonance spectroscopy, determination and localization of discogenic pain (cervical, thoracic, or lumbar); transmission of biomarker data for software analysis	0610T *	Prior Authorization goes through eviCore
Magnetic resonance spectroscopy, 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	0611T *	Prior Authorization goes through eviCore
Magnetic resonance spectroscopy, determination and localization of discogenic pain (cervical, thoracic, or lumbar); interpretation and report	0612T *	Prior Authorization goes through eviCore
Removal and replacement of substernal implantable defibrillator pulse generator	0614T *	Prior Authorization goes through eviCore
Automated quantification and characterization of coronary atherosclerotic plaque to assess severity of coronary disease, using data from coronary computed tomographic angiography; data preparation and transmission, computerized analysis of data, with review of computerized analysis output to reconcile discordant data, interpretation and report	0623T	Prior Authorization goes through eviCore
Automated quantification and characterization of coronary atherosclerotic plaque to assess severity of coronary disease, using data from coronary computed tomographic angiography; data preparation and transmission	0624T	Prior Authorization goes through eviCore
Automated quantification and characterization of coronary atherosclerotic plaque to assess severity of coronary disease, using data from coronary computed tomographic angiography; computerized analysis of data from coronary computed tomographic angiography	0625T	Prior Authorization goes through eviCore
Automated quantification and characterization of coronary atherosclerotic plaque to assess severity of coronary disease, using data from coronary computed tomographic angiography; review of computerized analysis output to reconcile discordant data, interpretation and report	0626T	Prior Authorization goes through eviCore
Computed tomography, breast, including 3D rendering, when performed, unilateral; without contrast material	0633T *	Prior Authorization goes through eviCore
Computed tomography, breast, including 3D rendering, when performed, unilateral; with contrast material(s)	0634T *	Prior Authorization goes through eviCore
Computed tomography, breast, including 3D rendering, when performed, unilateral; without contrast, followed by contrast material(s)	0635T *	Prior Authorization goes through eviCore
Computed tomography, breast, including 3D rendering, when performed, bilateral; without contrast material(s)	0636T *	Prior Authorization goes through eviCore

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 material(s)	0638T *	Prior Authorization goes through eviCore
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 without diagnostic MRI examination of the same anatomy (e.g., organ, gland, tissue, target structure) during the same session.	0648T	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 without diagnostic MRI examination of the same anatomy (eg, organ, gland, tissue, target structure) during the same session; single organ	0649T	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); 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	0710T	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	0712T	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)	71271 *	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 without contrast	C8901	Prior Authorization goes through eviCore
MRA Abdomen with and w/o contrast	C8902	Prior Authorization goes through eviCore
MRI Breast w/ contrast, unilateral	C8903	Prior Authorization goes through eviCore
MRI Breast w/o contrast, unilateral	C8904	Prior Authorization goes through eviCore
MRI Breast w. and w/o contrast, unilateral	C8905	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 myocardium)	C8909	Prior Authorization goes through eviCore
MRA chest w/o contrast (excluding myocardium)	C8910	Prior Authorization goes through eviCore
MRA chest w/ and w/o contrast (excluding myocardium)	C8911	Prior Authorization goes through eviCore
MRA lower extremity w/ contrast	C8912	Prior Authorization goes through eviCore
MRA lower extremity w/o contrast	C8913	Prior Authorization goes through eviCore
MRA lower extremity w/ and w/o contrast	C8914	Prior Authorization goes through eviCore
MRA pelvis w/ contrast	C8918	Prior Authorization goes through eviCore
MRA pelvis w/o contrast	C8919	Prior Authorization goes through eviCore
MRA pelvis w/ and w/o contrast	C8920	Prior Authorization goes through eviCore
Transthoracic echocardiography w/contrast for congenital cardiac anomalies; complete	C8921	Prior Authorization goes through eviCore
Transthoracic echocardiography w/contrast for congenital cardiac anomalies; f/u or limited study	C8922	Prior Authorization goes through eviCore
Transthoracic echocardiography w/contrast, real-time w/image documentation (2d), w/wo m-mode recording; complete	C8923	Prior Authorization goes through eviCore
Transthoracic echocardiography w/contrast, real-time w/image documentation (2d), w/wo m-mode recording; f/u or limited study	C8924	Prior Authorization goes through eviCore
Transesophageal echocardiography (TEE) 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	C8925	Prior Authorization goes through eviCore
Transesophageal echocardiography (TEE) with contrast, or without contrast followed by with contrast, for congenital cardiac anomalies; including probe placement, image acquisition, interpretation and report	C8926	Prior Authorization goes through eviCore
Transthoracic echocardiography w/contrast, real-time w/image documentation (2d), w/wo m-mode recording, during rest and cardiovascular stress test, w/interpretation and report	C8928	Prior Authorization goes through eviCore
Transthoracic echocardiography with 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	C8929	Prior Authorization goes through eviCore
Transthoracic echocardiography, with 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	C8930	Prior Authorization goes through eviCore
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	C8933	Prior Authorization goes through eviCore
MRA, W/ Dye, Upper Extremity	C8934	Prior Authorization goes through eviCore
MRA, W/O Dye, Upper Extr	C8935	Prior Authorization goes through eviCore
MRA, W/O & W/ Dye, Upper Extr	C8936	Prior Authorization goes through eviCore
Cardiac magnetic resonance imaging for morphology and function, quantification of segmental dysfunction; with strain imaging	C9762 *	Prior Authorization goes through eviCore
Cardiac magnetic resonance imaging for morphology and function, quantification of segmental dysfunction; with stress imaging	C9763 *	Prior Authorization goes through eviCore
Magnetic resonance cholangiopancreato-graphy (MRCP)	S8037	Prior Authorization goes through eviCore
Magnetic Resonance Imaging (MRI), Low-Field	S8042	Prior Authorization goes through eviCore
Electron Beam Computed Tomography (Also Known As Ultrafast CT, CINET)	S8092	Prior Authorization goes through eviCore
MSK (Musculoskeletal)	**Codes**	**Prior Authorization Requirement**
Arthroscopy, hip, surgical; with labral repair	29916	Prior Authorization goes through eviCore
Arthroscopy, hip, surgical; with acetabuloplasty (i.e., treatment of pincer lesion)	29915	Prior Authorization goes through eviCore
Arthroscopy, hip, surgical; with femoroplasty (i.e., treatment of cam lesion)	29914	Prior Authorization goes through eviCore
Arthroscopy, hip, surgical; with synovectomy	29863	Prior Authorization goes through eviCore
Arthroscopy, hip, surgical; with debridement/shaving of articular cartilage (chondroplasty), abrasion arthroplasty, and/or resection of labrum	29862	Prior Authorization goes through eviCore
Arthroscopy, hip, surgical; with removal of loose body or foreign body	29861	Prior Authorization goes through eviCore

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

Reconstruction of dislocating patella; with extensor realignment and/or muscle advancement or release (e.g., Campbell, Goldwaite type procedure)	27422	Prior Authorization goes through eviCore
Reconstruction of dislocating patella; (e.g., Hauser type procedure)	27420	Prior Authorization goes through eviCore
Anterior tibial tubercleplasty (e.g., Maquet type procedure)	27418	Prior Authorization goes through eviCore
Osteochondral autograft(s), knee, open (e.g., mosaicplasty) (includes harvesting of autograft[s])	27416	Prior Authorization goes through eviCore
Osteochondral allograft, knee, open	27415	Prior Authorization goes through eviCore
Autologous chondrocyte implantation, knee	27412	Prior Authorization goes through eviCore
Arthrotomy with meniscus repair, knee	27403	Prior Authorization goes through eviCore
Arthrotomy, with synovectomy, knee; anterior AND posterior including popliteal area	27335	Prior Authorization goes through eviCore
Arthrotomy, with synovectomy, knee; anterior OR posterior	27334	Prior Authorization goes through eviCore
Arthrotomy, with excision of semilunar cartilage (meniscectomy) knee; medial AND lateral	27333	Prior Authorization goes through eviCore
Arthrotomy, with excision of semilunar cartilage (meniscectomy) knee; medial OR lateral	27332	Prior Authorization goes through eviCore
Arthroscopy, shoulder, surgical; biceps tenodesis	29828	Prior Authorization goes through eviCore
Arthroscopy, shoulder, surgical; with rotator cuff repair	29827	Prior Authorization goes through eviCore
Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (i.e., arch) release, when performed (List separately in addition to code for primary procedure)	29826	Prior Authorization goes through eviCore
Arthroscopy, shoulder, surgical; with lysis and resection of adhesions, with or without manipulation	29825	Prior Authorization goes through eviCore
Arthroscopy, shoulder, surgical; distal claviculectomy including distal articular surface (Mumford procedure)	29824	Prior Authorization goes through eviCore
Arthroscopy, shoulder, surgical; debridement, extensive, 3 or more discrete structures (eg, humeral bone, humeral articular cartilage, glenoid bone, glenoid articular cartilage, biceps tendon, biceps anchor complex, labrum, articular capsule, articular side of the rotator cuff, bursal side of the rotator cuff, subacromial bursa, foreign body[ies])	29823	Prior Authorization goes through eviCore
Arthroscopy, shoulder, surgical; debridement, limited, 1 or 2 discrete structures (eg, humeral bone, humeral articular cartilage, glenoid bone, glenoid articular cartilage, biceps tendon, biceps anchor complex, labrum, articular capsule, articular side of the rotator cuff, bursal side of the rotator cuff, subacromial bursa, foreign body[ies])	29822	Prior Authorization goes through eviCore
Arthroscopy, shoulder, surgical; synovectomy, complete	29821	Prior Authorization goes through eviCore
Arthroscopy, shoulder, surgical; synovectomy, partial	29820	Prior Authorization goes through eviCore
Arthroscopy, shoulder, surgical; with removal of loose body or foreign body	29819	Prior Authorization goes through eviCore
Revision of total shoulder arthroplasty, including allograft when performed; humeral and glenoid component	23474	Prior Authorization goes through eviCore
Revision of total shoulder arthroplasty, including allograft when performed; humeral or glenoid component	23473	Prior Authorization goes through eviCore
Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (e.g., total shoulder))	23472	Prior Authorization goes through eviCore
Arthroplasty, glenohumeral joint; hemiarthroplasty	23470	Prior Authorization goes through eviCore
Capsulorrhaphy, glenohumeral joint, any type multi-directional instability	23466	Prior Authorization goes through eviCore
Capsulorrhaphy, glenohumeral joint, posterior, with or without bone block	23465	Prior Authorization goes through eviCore
Capsulorrhaphy, anterior, any type; with coracoid process transfer	23462	Prior Authorization goes through eviCore
Capsulorrhaphy, anterior, any type; with bone block	23460	Prior Authorization goes through eviCore
Capsulorrhaphy, anterior; with labral repair (e.g., Bankart procedure)	23455	Prior Authorization goes through eviCore
Capsulorrhaphy, anterior; Putti-Platt procedure or Magnuson type operation	23450	Prior Authorization goes through eviCore
Resection or transplantation of long tendon of biceps	23440	Prior Authorization goes through eviCore
Tenodesis of long tendon of biceps	23430	Prior Authorization goes through eviCore
Reconstruction of complete shoulder (rotator) cuff avulsion, chronic (includes acromioplasty)	23420	Prior Authorization goes through eviCore
Coracoacromial ligament release, with or without acromioplasty	23415	Prior Authorization goes through eviCore
Repair of ruptured musculotendinous cuff (e.g., rotator cuff) open; chronic	23412	Prior Authorization goes through eviCore
Repair of ruptured musculotendinous cuff (e.g., rotator cuff) open; acute	23410	Prior Authorization goes through eviCore
Acromioplasty or acromionectomy, partial, with or without coracoacromial ligament release	23130	Prior Authorization goes through eviCore
Claviculectomy; partial	23120	Prior Authorization goes through eviCore
Capsular contracture release (e.g., Sever type procedure)	23020	Prior Authorization goes through eviCore
Removal of subdeltoid calcareous deposits, open	23000	Prior Authorization goes through eviCore
Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level	22869	Prior Authorization goes through eviCore
Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; second level (List separately in addition to code for primary procedure)	22870	Prior Authorization goes through eviCore
Injection/infusion of neurolytic substance (e.g., alcohol, phenol, iced saline solutions), with or without other therapeutic substance; epidural, cervical or thoracic	62281	Prior Authorization goes through eviCore

Injection/infusion of neurolytic substance (e.g., alcohol, phenol, iced saline solutions), with or without other therapeutic substance; epidural, lumbar, sacral (caudal)	62282	Prior Authorization goes through eviCore
Injection(s), of diagnostic or therapeutic 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	62320	Prior Authorization goes through eviCore
Injection(s), of diagnostic or therapeutic 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)	62321	Prior Authorization goes through eviCore
Injection(s), of diagnostic or therapeutic 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); without imaging guidance	62322	Prior Authorization goes through eviCore
Injection(s), of diagnostic or therapeutic 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)	62323	Prior Authorization goes through eviCore
Injection(s), including indwelling catheter 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, cervical or thoracic; without imaging guidance	62324	Prior Authorization goes through eviCore
Injection(s), including indwelling catheter 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, cervical or thoracic; with imaging guidance (i.e., fluoroscopy or CT)	62325	Prior Authorization goes through eviCore
Injection(s), including indwelling catheter 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	62326	Prior Authorization goes through eviCore
Injection(s), including indwelling catheter 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); with imaging guidance (i.e., fluoroscopy or CT)	62327	Prior Authorization goes through eviCore
Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), cervical or thoracic, single level	64479	Prior Authorization goes through eviCore
Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), cervical or thoracic, each additional level (List separately in addition to code for primary procedure)	64480	Prior Authorization goes through eviCore
Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, single level	64483	Prior Authorization goes through eviCore
Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, each additional level (List separately in addition to code for primary procedure)	64484	Prior Authorization goes through eviCore
Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; single level	64490	Prior Authorization goes through eviCore
Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; second level (List separately in addition to code for primary procedure)	64491	Prior Authorization goes through eviCore
Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; third and any additional level(s) (List separately in addition to code for primary procedure)	64492	Prior Authorization goes through eviCore
Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level	64493	Prior Authorization goes through eviCore
Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; second level (List separately in addition to code for primary procedure)	64494	Prior Authorization goes through eviCore

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

Allograft, morselized, or placement of osteopromotive material, for spine surgery only (List separately in addition to code for primary procedure)	20930	Prior Authorization goes through eviCore
Allograft, structural, for spine surgery only (List separately in addition to code for primary procedure)	20931	Prior Authorization goes through eviCore
Autograft for spine surgery only (includes 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)	20936	Prior Authorization goes through eviCore
Autograft for spine surgery only (includes harvesting the graft); morselized (through separate skin or fascial incision) (List separately in addition to code for primary procedure)	20937	Prior Authorization goes through eviCore
Autograft for spine surgery only (includes harvesting the graft); structural, bicortical or tricortical (through separate skin or fascial incision) (List separately in addition to code for primary procedure)	20938	Prior Authorization goes through eviCore
Electrical stimulation to aid bone healing; noninvasive (nonoperative)	20974	Prior Authorization goes through eviCore
Electrical stimulation to aid bone healing; invasive (operative)	20975	Prior Authorization goes through eviCore
Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; lumbar	22214	Prior Authorization goes through eviCore
Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; cervicothoracic	22510	Prior Authorization goes through eviCore
Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; lumbosacral	22511	Prior Authorization goes through eviCore
Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; each additional cervicothoracic or lumbosacral vertebral body (List separately in addition to code for primary procedure)	22512	Prior Authorization goes through eviCore
Percutaneous vertebral augmentation, 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	22513	Prior Authorization goes through eviCore
Percutaneous vertebral augmentation, 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	22514	Prior Authorization goes through eviCore
Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed)	22515	Prior Authorization goes through eviCore
Lateral Extracavitary Approach Technique ArthrodesisProcedures on the Spine (Vertebral Column).	22532	Prior Authorization goes through eviCore
Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar	22533	Prior Authorization goes through eviCore
Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); thoracic or lumbar, each additional vertebral segment (List separately in addition to code for primary procedure)	22534	Prior Authorization goes through eviCore
Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2	22551	Prior Authorization goes through eviCore
Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace (List separately in addition to code for separate procedure)	22552	Prior Authorization goes through eviCore
Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2	22554	Prior Authorization goes through eviCore
Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar	22558	Prior Authorization goes through eviCore
Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); each additional interspace (List separately in addition to code for primary procedure)	22585	Prior Authorization goes through eviCore
Arthrodesis, posterior or posterolateral technique, single interspace; cervical below C2 segment	22600	Prior Authorization goes through eviCore
Arthrodesis, posterior or posterolateral technique, single interspace; lumbar (with lateral transverse technique, when performed)	22612	Prior Authorization goes through eviCore
Arthrodesis, posterior or posterolateral technique, single interspace; each additional interspace (List separately in addition to code for primary procedure)	22614	Prior Authorization goes through eviCore
Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar	22630	Prior Authorization goes through eviCore
Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; each additional interspace (List separately in addition to code for primary procedure)	22632	Prior Authorization goes through eviCore

Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace; lumbar	22633	Prior Authorization goes through eviCore
Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace; each additional interspace and segment (List separately in addition to code for primary procedure)	22634	Prior Authorization goes through eviCore
Exploration of spinal fusion	22830	Prior Authorization goes through eviCore
Posterior non-segmental instrumentation (eg, Harrington rod technique, pedicle fixation across 1 interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation) (List separately in addition to code for primary procedure)	22840	Prior Authorization goes through eviCore
Internal spinal fixation by wiring of spinous processes (List separately in addition to code for primary procedure)	22841	Prior Authorization goes through eviCore
Posterior segmental instrumentation (e.g., pedicle fixation, dual rods with multiple hooks and sublaminar wires); 3 to 6 vertebral segments (List separately in addition to code for primary procedure)	22842	Prior Authorization goes through eviCore
Posterior segmental instrumentation (e.g., pedicle fixation, dual rods with multiple hooks and sublaminar wires); 7 to 12 vertebral segments (List separately in addition to code for primary procedure)	22843	Prior Authorization goes through eviCore
Posterior segmental instrumentation (e.g., pedicle fixation, dual rods with multiple hooks and sublaminar wires); 13 or more vertebral segments (List separately in addition to code for primary procedure)	22844	Prior Authorization goes through eviCore
Anterior instrumentation; 2 to 3 vertebral segments (List separately in addition to code for primary procedure)	22845	Prior Authorization goes through eviCore
Anterior instrumentation; 4 to 7 vertebral segments (List separately in addition to code for primary procedure)	22846	Prior Authorization goes through eviCore
Anterior instrumentation; 8 or more vertebral segments (List separately in addition to code for primary procedure)	22847	Prior Authorization goes through eviCore
Pelvic fixation (attachment of caudal end of instrumentation to pelvic bony structures) other than sacrum (List separately in addition to code for primary procedure)	22848	Prior Authorization goes through eviCore
Removal of posterior segmental instrumentation	22852	Prior Authorization goes through eviCore
Insertion of interbody biomechanical 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	22853	Prior Authorization goes through eviCore
Insertion of intervertebral biomechanical 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)	22854	Prior Authorization goes through eviCore
Removal of anterior instrumentation	22855	Prior Authorization goes through eviCore
Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection); single interspace, cervical	22856	Prior Authorization goes through eviCore
Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), single interspace, lumbar	22857	Prior Authorization goes through eviCore
Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection); second level, cervical (List separately in addition to code for primary procedure)	22858	Prior Authorization goes through eviCore
Insertion of intervertebral biomechanical device(s) (e.g., synthetic cage, mesh, methylmethacrylate) to intervertebral disc space or vertebral body defect without interbody arthrodesis, each contiguous defect (List separately in addition to code for primary procedure)	22859	Prior Authorization goes through eviCore
Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical	22861	Prior Authorization goes through eviCore
Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; lumbar	22862	Prior Authorization goes through eviCore
Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level	22867	Prior Authorization goes through eviCore
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)	22868	Prior Authorization goes through eviCore
Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; second level (List separately in addition to code for primary procedure)	22870	Prior Authorization goes through eviCore

Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, any method utilizing needle based technique to remove disc material under fluoroscopic imaging or other form of indirect visualization, with discography and/or epidural injection(s) at the treated level(s), when performed, single or multiple levels, lumbar	62287	Prior Authorization goes through eviCore
Endoscopic decompression of spinal cord, nerve root(s), including laminotomy, partial facetectomy, foraminotomy, discectomy and/or excision of herniated intervertebral disc, 1 interspace, lumbar	62380	Prior Authorization goes through eviCore
Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (e.g., spinal stenosis), 1 or 2 vertebral segments; cervical	63001	Prior Authorization goes through eviCore
Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy	63005	Prior Authorization goes through eviCore
Laminectomy with removal of abnormal facets and/or pars inter- articularis with decompression of cauda equina and nerve roots for spondylolisthesis, lumbar (Gill type procedure)	63012	Prior Authorization goes through eviCore
Laminectomy with exploration and/or decompression of spinal	63015	Prior Authorization goes through eviCore
Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (e.g., spinal stenosis), more than 2 vertebral segments; lumbar	63017	Prior Authorization goes through eviCore
Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, cervical	63020	Prior Authorization goes through eviCore
Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar	63030	Prior Authorization goes through eviCore
Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; each additional interspace, cervical or lumbar (List separately in addition to code for primary procedure)	63035	Prior Authorization goes through eviCore
Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; cervical	63040	Prior Authorization goes through eviCore
Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; lumbar	63042	Prior Authorization goes through eviCore
Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; each additional cervical interspace (List separately in addition to code for primary procedure)	63043	Prior Authorization goes through eviCore
Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; each additional lumbar interspace (List separately in addition to code for primary procedure)	63044	Prior Authorization goes through eviCore
Laminectomy, facetectomy and foraminotomy (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	63045	Prior Authorization goes through eviCore
Laminectomy, facetectomy and foraminotomy (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	63047	Prior Authorization goes through eviCore
Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; each additional vertebral segment, cervical, thoracic, or lumbar (List separately in addition to code for primary procedure)	63048	Prior Authorization goes through eviCore
Laminoplasty, cervical, with decompression of the spinal cord, 2 or more vertebral segments;	63050	Prior Authorization goes through eviCore
Laminoplasty, cervical, with decompression of the spinal cord, 2 or more vertebral segments; with reconstruction of the posterior bony elements (including the application of bridging bone graft and non-segmental fixation devices [e.g., wire, suture, mini- plates], when performed)	63051	Prior Authorization goes through eviCore
Transpedicular approach with decompression 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)	63056	Prior Authorization goes through eviCore
Transpedicular approach with decompression 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 for primary procedure)	63057	Prior Authorization goes through eviCore
Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, single interspace	63075	Prior Authorization goes through eviCore

Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, each additional interspace (List separately in addition to code for primary procedure)	63076	Prior Authorization goes through eviCore
Vertebral corpectomy (vertebral body resection), partial or complete, anterior approach with decompression of spinal cord and/or nerve root(s); cervical, single segment	63081	Prior Authorization goes through eviCore
Vertebral corpectomy (vertebral body resection), partial or complete, anterior approach with decompression of spinal cord and/or nerve root(s); cervical, each additional segment (List separately in addition to code for primary procedure)	63082	Prior Authorization goes through eviCore
Removal of total disc arthroplasty (artificial disc), anterior approach, each additional interspace, cervical (List separately in addition to code for primary procedure)	0095T	Prior Authorization goes through eviCore
Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, each additional interspace, cervical (List separately in addition to code for primary procedure)	0098T	Prior Authorization goes through eviCore
Removal of total disc arthroplasty, (artificial disc), anterior approach, each additional interspace, lumbar (List separately in addition to code for primary procedure)	0164T	Prior Authorization goes through eviCore
Arthrodesis, sacroiliac joint, percutaneous, with image guidance, includes placement of intra-articular implant(s)	0775T	Prior Authorization goes through eviCore
Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression); second interspace, lumbar (List separately in addition to code for primary procedure)	22860	Prior Authorization goes through eviCore
Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, each additional interspace, lumbar (List separately in addition to code for primary procedure)	0165T	Prior Authorization goes through eviCore
Percutaneous laminotomy/laminectomy (interlaminar approach) for decompression of neural elements, (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy), any method, under indirect image guidance (e.g., fluoroscopic, CT), single or multiple levels, unilateral or bilateral; cervical or thoracic	0274T	Prior Authorization goes through eviCore
Percutaneous laminotomy/laminectomy (interlaminar approach) for decompression of neural elements, (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy), any method, under indirect image guidance (e.g., fluoroscopic, CT), single or multiple levels, unilateral or bilateral; lumbar	0275T	Prior Authorization goes through eviCore
Arthrodesis, pre-sacral interbody technique, including disc space preparation, discectomy, with posterior instrumentation, with image guidance, includes bone graft when performed, L5-S1 interspace	22586	Prior Authorization goes through eviCore
Arthrodesis, posterior technique, atlas-axis (C1-C2)	22595	Prior Authorization goes through eviCore
Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device	27279	Prior Authorization goes through eviCore
Arthrodesis, open, sacroiliac joint, including obtaining bone graft, including instrumentation, when performed	27280	Prior Authorization goes through eviCore
Repair, primary, torn ligament and/or capsule, knee; collateral	27405	Prior Authorization goes through eviCore
Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and excision of herniated intervertebral disc, and repair of annular defect with implantation of bone anchored annular closure device, including annular defect measurement, alignment and sizing assessment, and image guidance; 1 interspace, lumbar	C9757	Prior Authorization goes through eviCore
Osteogenesis stimulator, electrical, noninvasive, spinal applications	E0748	Prior Authorization goes through eviCore
Osteogenesis stimulator, electrical, surgically implanted	E0749	Prior Authorization goes through eviCore
Implantable neurostimulator, pulse generator, any type	L8679	Prior authorization is required.
Implantable neurostimulator electrode, each	L8680	Prior authorization is required.