HIGHMARK HEALTH OPTIONS

2024
Prior Authorization List

The Provider Authorization List was last updated March 15, 2024.

- 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.

Code	Code Description	Prior Authorization Requirement	Referenced Policy, If applicable	Vendor Review Required
0100	All Inclusive Rate-All-inclusive room and board plus ancillary	Prior authorization is required. Coverage is limited to LTSS members.		
0101	All Inclusive Rate-All-inclusive room and board	Prior authorization is required. Coverage is limited to LTSS members.		
00104	Anesthesia for electroconvulsive therapy	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1162 Electroconvulsive Therapy	
0114	Inpatient (IP) Acute Psychiatric	Prior authorization is required. Reference policies for additional information.	HHO-DE-RP-1005 Facility-Based Behavioral Health Services	
0120	Room & Board Semiprivate (Two Beds)-General Classification	For Long Term Acute Care, prior authorization is required and member must meet medical necessity criteria. Concurrent reviews are required every 3-7 days.		
0124	Inpatient (IP) Acute Psychiatric (semi-private two bed)	Prior authorization is required. Reference policies for additional information.	HHO-DE-RP-1005 Facility-Based Behavioral Health Services	
0129	Room & Board-Semiprivate (Two-Beds)-Other	Prior authorization is required. Coverage is limited to LTSS members.		
00170	Anesthesia for procedures on the head	Prior authorization is required.	HHO-DE-RP-1004 Dental Services Under the Medical Benefit	
0190	Subacute Care-General	Prior authorization is required. Skilled nursing benefit is limited to 30 days per calendar year.		
0191	Subacute Care-Level I	Prior authorization is required. Skilled nursing benefit is limited to 30 days per calendar year.		
0192	Subacute Care-Level II	Prior authorization is required. Skilled nursing benefit is limited to 30 days per calendar year.		
0193	Subacute Care-Level III	Prior authorization is required. Skilled nursing benefit is limited to 30 days per calendar year.		
0194	Subacute Care-Level IV	Prior authorization is required. Skilled nursing benefit is limited to 30 days per calendar year.		
0199	Subacute Care-Other Subacute Care	Prior authorization is required. Coverage is limited to LTSS members.		
0651	Hospice Service-Routine Home Care	Prior authorization is required.		
0652	Hospice Service-Continuous Home Care	Prior authorization is required.		
0655	Hospice Service-Inpatient Respite Care	Prior authorization is required.		
0656	Hospice Service-General Inpatient Care Nonrespite	Prior authorization is required.		
0657	Hospice Service-Physician Services	Prior authorization is required.		
0658	Hospice Service-Hospice Room & Board-Nursing Facility	Prior authorization is required. Coverage is limited to LTSS members.		
0912	Behavioral Health Treatment/Services-Extension of 090X-Partial HospitalizationLess Intensive	Prior authorization is required. Reference policies for additional information.	HHO-DE-RP-1005 Facility-Based Behavioral Health Services	
0913	Behavioral Health Treatment/Services-Extension of 090X-Partial HospitalizationIntensive	Prior authorization is required. Reference policies for additional information.	HHO-DE-RP-1005 Facility-Based Behavioral Health Services	
01999	Unlisted anesthesia procedure(s)	Prior authorization is required.		
10040	Acne surgery (eg, marsupialization, opening or removal of multiple milia, comedones, cysts, pustules)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1130 Removal of Benign or Premalignant Skin Lesions	
11200	Removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1130 Removal of Benign or Premalignant Skin Lesions	
11201	Removal of skin tags, multiple fibrocutaneous tags, any area; each additional 10 lesions, or part thereof (List separately in addition to code for primary procedure)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1130 Removal of Benign or Premalignant Skin Lesions	
11300	Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.5 cm or less	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1130 Removal of Benign or Premalignant Skin Lesions	
11301	Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.6 to 1.0 cm	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1130 Removal of Benign or Premalignant Skin Lesions	
11302	Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 1.1 to 2.0 cm	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1130 Removal of Benign or Premalignant Skin Lesions	
11303	Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter over 2.0 cm	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1130 Removal of Benign or Premalignant Skin Lesions	
11305	Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1130 Removal of Benign or Premalignant Skin Lesions	
11306	Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.6 to 1.0 cm	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1130 Removal of Benign or Premalignant Skin Lesions	
11307	Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 1.1 to 2.0 cm	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1130 Removal of Benign or Premalignant Skin Lesions	
11308	Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter over 2.0 cm	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1130 Removal of Benign or Premalignant Skin Lesions	
11310	Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.5 cm or less	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1130 Removal of Benign or Premalignant Skin Lesions	
11311	Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.6 to 1.0 cm	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1130 Removal of Benign or Premalignant Skin Lesions	
11312	Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 1.1 to 2.0 cm	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1130 Removal of Benign or Premalignant Skin Lesions	
11313	Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter over 2.0 cm	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1130 Removal of Benign or Premalignant Skin Lesions	
11400	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 0.5 cm or less	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1130 Removal of Benign or Premalignant Skin Lesions	
11401	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 0.6 to 1.0 cm	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1130 Removal of Benign or Premalignant Skin Lesions	
11402	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 1.1 to 2.0 cm	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1130 Removal of Benign or Premalignant Skin Lesions	
11403	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 2.1 to 3.0 cm	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1130 Removal of Benign or Premalignant Skin Lesions	
11406	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter over 4.0 cm	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1130 Removal of Benign or Premalignant Skin Lesions	

11420	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.5 cm or less	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1130 Removal of Benign or Premalignant Skin Lesions	
11421	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.6 to 1.0 cm	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1130 Removal of Benign or Premalignant Skin Lesions	
11422	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 1.1 to 2.0 cm	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1130 Removal of Benign or Premalignant Skin Lesions	
11423	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 2.1 to 3.0 cm	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1130 Removal of Benign or Premalignant Skin Lesions	
11424	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 3.1 to 4.0 cm	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1130 Removal of Benign or Premalignant Skin Lesions	
11426	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter over 4.0 cm	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1130 Removal of Benign or Premalignant Skin Lesions	
11440	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	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1130 Removal of Benign or Premalignant Skin Lesions	
11441	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	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1130 Removal of Benign or Premalignant Skin Lesions	
11442	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	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1130 Removal of Benign or Premalignant Skin Lesions	
11443	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	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1130 Removal of Benign or Premalignant Skin Lesions	
11444	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	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1130 Removal of Benign or Premalignant Skin Lesions	
11446	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	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1130 Removal of Benign or Premalignant Skin Lesions	
11920	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.0 sq cm or less	Prior authorization is required and medical necessity criteria must be met. Reference policies for additional information.	HHO-DE-MP-1027 Breast Reconstructive Surgery	
11921	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.1 to 20.0 sq cm	Prior authorization is required and medical necessity criteria must be met. Reference policies for additional information.	HHO-DE-MP-1027 Breast Reconstructive Surgery	
11922	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; each additional 20.0 sq cm, or part thereof (List separately in addition to code for primary procedure)	Prior authorization is required and medical necessity criteria must be met. Reference policies for additional information.	HHO-DE-MP-1027 Breast Reconstructive Surgery	
11950	Subcutaneous injection of filling material (eg, collagen); 1 cc or less	Prior authorization is required and medical necessity criteria must be met.		
11951	Subcutaneous injection of filling material (eg, collagen); 1.1 to 5.0 cc	Prior authorization is required and medical necessity criteria must be met.		
11952	Subcutaneous injection of filling material (eg, collagen); 5.1 to 10.0 cc	Prior authorization is required and medical necessity criteria must be met.		
11954	Subcutaneous injection of filling material (eg, collagen); over 10.0 cc	Prior authorization is required and medical necessity criteria must be met.		
11960	Insertion of tissue expander(s) for other than breast, including subsequent expansion	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1216 Gender Affirmation Services	
11970	Replacement of tissue expander with permanent testicular insertion	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1216 Gender Affirmation Services	
11980	Subcutaneous hormone pellet implantation (implantation of estradiol and/or testosterone pellets beneath the skin)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1033 Implantable Hormone Replacement Pellets	
14000	Adjacent tissue transfer or rearrangement, trunk; defect 10 sq. cm or less	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1216 Gender Affirmation Services	
14001	Adjacent tissue transfer or rearrangement, trunk; defect 10.1 sq. cm to 30.0 sq. cm	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1216 Gender Affirmation Services	
14041	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	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1216 Gender Affirmation Services	
15150	Tissue cultured skin autograft, trunk, arms, legs; first 25 sq cm or less	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1257 Bioengineered Skin and Skin Replacement Therapy	
15151	Tissue cultured skin autograft, trunk, arms, legs; additional 1 sq cm to 75 sq cm (List separately in addition to code for primary procedure)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1257 Bioengineered Skin and Skin Replacement Therapy	
15152	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)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1257 Bioengineered Skin and Skin Replacement Therapy	
15155	Tissue cultured skin autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 25 sq cm or less	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1257 Bioengineered Skin and Skin Replacement Therapy	
15156	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)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1257 Bioengineered Skin and Skin Replacement Therapy	
15157	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)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1257 Bioengineered Skin and Skin Replacement Therapy	
15271	Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1257 Bioengineered Skin and Skin Replacement Therapy	
15272	Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (List separately in addition to code for primary procedure)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1257 Bioengineered Skin and Skin Replacement Therapy	
15273	Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1257 Bioengineered Skin and Skin Replacement Therapy	
15274	Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1257 Bioengineered Skin and Skin Replacement Therapy	

15275	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1257 Bioengineered Skin and Skin Replacement Therapy	
15276	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (List separately in addition to code for primary procedure)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1257 Bioengineered Skin and Skin Replacement Therapy	
15277	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1257 Bioengineered Skin and Skin Replacement Therapy	
15278	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1257 Bioengineered Skin and Skin Replacement Therapy	
15775	Punch graft for hair transplant; 1 to 15 punch grafts	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service.		
15776	Punch graft for hair transplant; more than 15 punch grafts	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service.		
15777	Implantation of biologic implant (eg, acellular dermal matrix) for soft tissue reinforcement (ie, breast, trunk) (List separately in addition to code for primary procedure)	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service. Reference policies for additional information.	HHO-DE-MP-1216 Gender Affirmation Services and HHO-DE-MP-1257 Bioengineered Skin and Skin Replacement Therapy	
15780	Dermabrasion; total face (eg, for acne scarring, fine wrinkling, rhytids, general keratosis)	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service.		
15781	Dermabrasion; segmental, face	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service.		
15782	Dermabrasion; regional, other than face	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service.		
15783	Dermabrasion; superficial, any site (eg, tattoo removal)	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service.		
15786	Abrasion; single lesion (eg, keratosis, scar)	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service.		
15787	Abrasion; each additional 4 lesions or less (List separately in addition to code for primary procedure)	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service.		
15788	Chemical peel, facial; epidermal	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service.		
15789	Chemical peel, facial; dermal	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service.		
15792	Chemical peel, nonfacial; epidermal	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service.		
15793	Chemical peel, nonfacial; dermal	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service.		
15819	Cervicoplasty	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service.		
15820	Blepharoplasty, lower eyelid;	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service.		
15821	Blepharoplasty, lower eyelid; with extensive herniated fat pad	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service.		
15822	Blepharoplasty, upper eyelid;	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service.		
15823	Blepharoplasty, upper eyelid; with excessive skin weighting down lid	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service.		
15824	Rhytidectomy; forehead	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service.		
15825	Rhytidectomy; neck with platysmal tightening (platysmal flap, P-flap)	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service.		
15826	Rhytidectomy; glabellar frown lines	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service.		
15828	Rhytidectomy; cheek, chin and neck	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service.		
15829	Rhytidectomy; superficial musculoaponeurotic system (SMAS) flap	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service.		
15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service. Reference policies for additional information.	HHO-DE-MP-1137 Abdominoplasty and Panniculectomy	
15832	Excision, excessive skin and subcutaneous tissue (includes lipectomy); thigh	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service.		
15833	Excision, excessive skin and subcutaneous tissue (includes lipectomy); leg	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service.		
15834	Excision, excessive skin and subcutaneous tissue (includes lipectomy); hip	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service.		

15835	Excision, excessive skin and subcutaneous tissue (includes lipectomy); buttock	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service.		
15836	Excision, excessive skin and subcutaneous tissue (includes lipectomy); arm	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service.		
15837	Excision, excessive skin and subcutaneous tissue (includes lipectomy); forearm or hand	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service.		
15838	Excision, excessive skin and subcutaneous tissue (includes lipectomy); submental fat pad	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service.		
15839	Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service. Reference policies for additional information.	HHO-DE-MP-1137 Labiaplasty	
15847	Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (eg, abdominoplasty) (includes umbilical transposition and fascial plication) (List separately in addition to code for primary procedure)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1003 Abdominoplasty and Panniculectomy	
15876	Suction assisted lipectomy; head and neck	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1216 Gender Affirmation Services	
15877	Suction assisted lipectomy; trunk	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service.		
15878	Suction assisted lipectomy; upper extremity	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service. Reference policies for additional information.	HHO-DE-MP-1137 Hyperhidrosis	
15879	Suction assisted lipectomy; lower extremity	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service.		
15999	Unlisted procedure, excision pressure ulcer	Prior authorization is required.		
17000	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); first lesion	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1130 Removal of Benign or Premalignant Skin Lesions	
17003	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)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1130 Removal of Benign or Premalignant Skin Lesions	
17004	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses), 15 or more lesions	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1130 Removal of Benign or Premalignant Skin Lesions	
17106	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); less than 10 sq cm	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1100 Surgical Treatment of Varicose Veins	
17107	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); 10.0 to 50.0 sq cm	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1100 Surgical Treatment of Varicose Veins	
17108	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); over 50.0 sq cm	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1100 Surgical Treatment of Varicose Veins	
17110	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	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1130 Removal of Benign or Premalignant Skin Lesions	
17111	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	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1130 Removal of Benign or Premalignant Skin Lesions	
17311	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	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1034 Treatment of Malignant Skin Lesions	
17312	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)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1034 Treatment of Malignant Skin Lesions	
17313	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	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1034 Treatment of Malignant Skin Lesions	
17314	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)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1034 Treatment of Malignant Skin Lesions	
17315	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)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1034 Treatment of Malignant Skin Lesions	
17999	Unlisted procedure: Skin, mucous membrane and subcutaneous tissue	Prior authorization is required. Reference policies for additional information. DE-MP-1137 Hyperhidrosis Prior authorization is required for not otherwise classified codes.		

19105	Ablation, cryosurgical, of fibroadenoma, including ultrasound guidance, each fibroadenoma	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1218 Radiofrequency Ablation of Miscellaneous Solid Tumors	
19301	Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy);	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1027 Breast Reconstructive Surgery	
19302	Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy); with axillary lymphadenectomy	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1027 Breast Reconstructive Surgery	
19303	Mastectomy, simple, complete	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1027 Breast Reconstructive Surgery	
19305	Mastectomy, radical, including pectoral muscles, axillary lymph nodes	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1027 Breast Reconstructive Surgery	
19306	Mastectomy, radical, including pectoral muscles, axillary and internal mammary lymph nodes (Urban type operation)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1027 Breast Reconstructive Surgery	
19307	Mastectomy, modified radical, including axillary lymph nodes, with or without pectoralis minor muscle, but excluding pectoralis major muscle	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1027 Breast Reconstructive Surgery	
19316	Mastopexy	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service. Reference policies for additional information.	HHO-DE-MP-1216 Gender Affirmation Services and HHO-DE-MP-1257 Bioengineered Skin and Skin Replacement Therapy	
19318	Breast reduction	Prior authorization is required and medical necessity criteria must be met. Reference policies for additional information.	HHO-DE-MP-1027 Breast Reconstructive Surgery	
19325	Breast augmentation with implant	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service. Reference policies for additional information.	HHO-DE-MP-1027 Breast Reconstructive Surgery and HHO-DE-MP-1216 Gender Affirmation Services	
19328	Removal of intact breast implant	Prior authorization is required and medical necessity criteria must be met. Reference policies for additional information.	HHO-DE-MP-1027 Breast Reconstructive Surgery	
19330	Removal of ruptured breast implant, including implant contents (eg, saline, silicone gel)	Prior authorization is required and medical necessity criteria must be met. Reference policies for additional information.	HHO-DE-MP-1027 Breast Reconstructive Surgery	
19340	Insertion of breast implant on same day of mastectomy (ie, immediate)	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service. Reference policies for additional information.	HHO-DE-MP-1027 Breast Reconstructive Surgery and HHO-DE-MP-1216 Gender Affirmation Services	
19342	Insertion or replacement of breast implant on separate day from mastectomy	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service. Reference policies for additional information.	HHO-DE-MP-1027 Breast Reconstructive Surgery and HHO-DE-MP-1216 Gender Affirmation Services	
19350	Nipple/areola reconstruction	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service. Reference policies for additional information.	HHO-DE-MP-1027 Breast Reconstructive Surgery and HHO-DE-MP-1216 Gender Affirmation Services	
19355	Correction of inverted nipples	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service.		
19357	Tissue expander placement in breast reconstruction, including subsequent expansion(s)	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service. Reference policies for additional information.	HHO-DE-MP-1027 Breast Reconstructive Surgery and HHO-DE-MP-1216 Gender Affirmation Services	
19361	Breast reconstruction; with latissimus dorsi flap	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service. Reference policies for additional information.	HHO-DE-MP-1027 Breast Reconstructive Surgery and HHO-DE-MP-1216 Gender Affirmation Services	
19364	Breast reconstruction; with free flap (eg, fTRAM, DIEP, SIEA, GAP flap)	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service. Reference policies for additional information.	HHO-DE-MP-1027 Breast Reconstructive Surgery and HHO-DE-MP-1216 Gender Affirmation Services	
19367	Breast reconstruction; with single-pedicled transverse rectus abdominis myocutaneous (TRAM) flap	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service. Reference policies for additional information.	HHO-DE-MP-1027 Breast Reconstructive Surgery	
19368	Breast reconstruction; with single-pedicled transverse rectus abdominis myocutaneous (TRAM) flap, requiring separate microvascular anastomosis (supercharging)	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service. Reference policies for additional information.	HHO-DE-MP-1027 Breast Reconstructive Surgery and HHO-DE-MP-1216 Gender Affirmation Services	
19369	Breast reconstruction; with bipedicled transverse rectus abdominis myocutaneous (TRAM) flap	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service. Reference policies for additional information.	HHO-DE-MP-1027 Breast Reconstructive Surgery and HHO-DE-MP-1216 Gender Affirmation Services	
19370	Revision of peri-implant capsule, breast, including capsulotomy, capsulorrhaphy and/or partial capsulectomy	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service.		
19371	Peri-implant capsulectomy, breast, complete, including removal of all intracapsular contents	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service.		
19380	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)	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service. Reference policies for additional information.	HHO-DE-MP-1216 Gender Affirmation Services and HHO-DE-MP-1257 Bioengineered Skin and Skin Replacement Therapy	
19396	Preparation of moulage for custom breast implant	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service. Reference policies for additional information.	HHO-DE-MP-1027 Breast Reconstructive Surgery	
19499	Unlisted procedure, breast	Prior authorization is required for not otherwise classified codes and medical necessity criteria must be met. Cosmetic procedures are a non-covered service. Reference policies for additional information.	HHO-DE-MP-1027 Breast Reconstructive Surgery	
20550	Injection(s); single tendon sheath, or ligament, aponeurosis (e.g., plantar "fascia"	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1253 Ultrasound Guidance for Joint, Tendon, Tendon Sheath and Trigger Point Injections	
20604	Arthrocentesis, aspiration and/or injection, small joint or bursa (e.g., fingers, toes); with ultrasound guidance, with permanent recording and reporting	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1253 Ultrasound Guidance for Joint, Tendon, Tendon Sheath and Trigger Point Injections	
20606	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	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1253 Ultrasound Guidance for Joint, Tendon, Tendon Sheath and Trigger Point Injections	
20611	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	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1253 Ultrasound Guidance for Joint, Tendon, Tendon Sheath and Trigger Point Injections	
20930	Allograft, morselized, or placement of osteopromotive material, for spine surgery only (List separately in addition to code for primary procedure)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
20931	Allograft, structural, for spine surgery only (List separately in addition to code for primary procedure)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
20932	Allograft, includes templating, cutting, placement and internal fixation, when performed; osteoarticular, including articular surface and contiguous bone (List separately in addition to code for primary procedure)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1122 Orthopedic Applications of Stem-Cell Therapy	

20933	Allograft, includes templating, cutting, placement and internal fixation, when performed; hemicortical intercalary, partial (ie, hemicylindrical) (List separately in addition to code for primary procedure)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1122 Orthopedic Applications of Stem-Cell Therapy	
20934	Allograft, includes templating, cutting, placement and internal fixation, when performed; intercalary, complete (ie, cylindrical) (List separately in addition to code for primary procedure)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1122 Orthopedic Applications of Stem-Cell Therapy	
20936	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)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
20937	Autograft for spine surgery only (includes harvesting the graft); morselized (through separate skin or fascial incision) (List separately in addition to code for primary procedure)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
20938	Autograft for spine surgery only (includes harvesting the graft); structural, bicortical or tricortical (through separate skin or fascial incision) (List separately in addition to code for primary procedure)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
20974	Electrical stimulation to aid bone healing; noninvasive (nonoperative)	Prior authorization is managed by EviCore. Reference policies for additional information.	HHO-DE-MP-1148 Electrical Bone Growth Stimulation Spinal and HHO-DE-MP-1149 Non-Spinal Bone Growth Stimulation	Prior authorization is managed by EviCore.
20975	Electrical stimulation to aid bone healing; invasive (operative)	Prior authorization is managed by EviCore. Reference policies for additional information.	HHO-DE-MP-1148 Electrical Bone Growth Stimulation Spinal and HHO-DE-MP-1149 Non-Spinal Bone Growth Stimulation	Prior authorization is managed by EviCore.
20979	Low intensity ultrasound stimulation to aid bone healing, noninvasive (nonoperative)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1251 Ultrasound Osteogenesis Stimulator	
20982	Ablation therapy for reduction or eradication of 1 or more bone tumors (eg, metastasis) including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed; radiofrequency	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1218 Radiofrequency Ablation of Miscellaneous Solid Tumors	
20983	Ablation therapy for reduction or eradication of 1 or more bone tumors (eg, metastasis) including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed; cryoablation	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1218 Radiofrequency Ablation of Miscellaneous Solid Tumors	
20999	Unlisted procedure, musculoskeletal system, general	Prior authorization is required.		
21010	Arthrotomy, temporomandibular joint	Prior authorization is required.		
21050	Condylectomy, temporomandibular joint (separate procedure)	Prior authorization is required.		
21060	Meniscectomy, partial or complete, temporomandibular joint (separate procedure)	Prior authorization is required.		
21070	Coronoidectomy (separate procedure)	Prior authorization is required.		
21073	Manipulation of temporomandibular joint(s) (TMJ), therapeutic, requiring an anesthesia service (ie, general or monitored anesthesia care)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1136 Temporomandibular Joint Dysfunction	
21089	Unlisted maxillofacial prosthetic procedure	Prior authorization is required.		
21116	Injection procedure for temporomandibular joint arthrography	Prior authorization is required.		
21122	Genioplasty; sliding osteotomies, 2 or more osteotomies (eg, wedge excision or bone wedge reversal for asymmetrical chin)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1064 Diagnosis and Treatment of Obstructive Sleep Apnea in Adults	
21123	Genioplasty; sliding, augmentation with interpositional bone grafts (includes obtaining autografts)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1064 Diagnosis and Treatment of Obstructive Sleep Apnea in Adults	
21195	Reconstruction of mandibular rami and/or body, sagittal split; without internal rigid fixation	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1064 Diagnosis and Treatment of Obstructive Sleep Apnea in Adults	
21196	Reconstruction of mandibular rami and/or body, sagittal split; with internal rigid fixation	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1064 Diagnosis and Treatment of Obstructive Sleep Apnea in Adults	
21199	Osteotomy, mandible, segmental; with genioglossus advancement	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1064 Diagnosis and Treatment of Obstructive Sleep Apnea in Adults	
21240	Arthroplasty, temporomandibular joint, with or without autograft (includes obtaining graft)	Prior authorization is required.		
21242	Arthroplasty, temporomandibular joint, with allograft	Prior authorization is required.		
21299	Unlisted craniofacial and maxillofacial procedure	Prior authorization is required.		
21480	Closed treatment of temporomandibular dislocation; initial or subsequent	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1136 Temporomandibular Joint Dysfunction	
21485	Closed treatment of temporomandibular dislocation; complicated (eg, recurrent requiring intermaxillary fixation or splinting), initial or subsequent	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1136 Temporomandibular Joint Dysfunction	
21490	Open treatment of temporomandibular dislocation	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1136 Temporomandibular Joint Dysfunction	
21499	Musculoskeletal procedure: Head	Prior authorization is required.		
21685	Hyoid myotomy and suspension	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1064 Diagnosis and Treatment of Obstructive Sleep Apnea in Adults	
21812	Open treatment of rib fracture(s) with internal fixation, includes thoracoscopic visualization when performed, unilateral; 4-6 ribs	Prior authorization is required.		
21899	Procedure: Neck or thorax	Prior authorization is required.		
22214	Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; lumbar	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
22510	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; cervicothoracic	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
22511	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; lumbosacral	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
22512	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; each additional cervicothoracic or lumbosacral vertebral body (List separately in addition to code for primary procedure)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.

22513	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	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
22514	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	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
22515	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
22526	Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; single level	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
22527	Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; 1 or more additional levels (List separately in addition to code for primary procedure)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
22532	Lateral Extracavitary Approach Technique ArthrodesisProcedures on the Spine (Vertebral Column).	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
22533	Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
22534	Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); thoracic or lumbar, each additional vertebral segment (List separately in addition to code for primary procedure)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
22551	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
22552	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace (List separately in addition to code for separate procedure)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
22554	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
22558	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
22585	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); each additional interspace (List separately in addition to code for primary procedure)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
22586	Arthrodesis, pre-sacral interbody technique, including disc space preparation, discectomy, with posterior instrumentation, with image guidance, includes bone graft when performed, L5-S1 interspace	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
22595	Arthrodesis, posterior technique, atlas-axis (C1-C2)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
22600	Arthrodesis, posterior or posterolateral technique, single interspace; cervical below C2 segment	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
22612	Arthrodesis, posterior or posterolateral technique, single interspace; lumbar (with lateral transverse technique, when performed)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
22614	Arthrodesis, posterior or posterolateral technique, single interspace; each additional interspace (List separately in addition to code for primary procedure)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
22630	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
22632	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)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
22633	Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace; lumbar	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
22634	Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace; each additional interspace and segment (List separately in addition to code for primary procedure)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
22830	Exploration of spinal fusion	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
22836	Anterior thoracic vertebral body tethering, including thoracoscopy, when performed; up to 7 vertebral segments			
22837	Anterior thoracic vertebral body tethering, including thoracoscopy, when performed; 8 or more vertebral segments			
22838	Arthrodesis, sacroiliac joint, percutaneous, with image guidance, including placement of intra-articular implant(s) (eg, bone allograft[s], synthetic device[s]), without placement of transfixation device			
22840	Posterior non-segmental instrumentation (eg, Harrington rod technique, pedicle fixation across 1 interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation) (List separately in addition to code for primary procedure)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.

22841	Internal spinal fixation by wiring of spinous processes (List separately in addition to code for primary procedure)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
22842	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)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
22843	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)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
22844	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)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
22845	Anterior instrumentation; 2 to 3 vertebral segments (List separately in addition to code for primary procedure)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
22846	Anterior instrumentation; 4 to 7 vertebral segments (List separately in addition to code for primary procedure)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
22847	Anterior instrumentation; 8 or more vertebral segments (List separately in addition to code for primary procedure)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
22848	Pelvic fixation (attachment of caudal end of instrumentation to pelvic bony structures) other than sacrum (List separately in addition to code for primary procedure)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
22852	Removal of posterior segmental instrumentation	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
22853	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	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
22854	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)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
22855	Removal of anterior instrumentation	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
22856	Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection); single interspace, cervical	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
22857	Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), single interspace, lumbar	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
22858	Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection); second level, cervical (List separately in addition to code for primary procedure)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
22859	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)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
22860	Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression); second interspace, lumbar (List separately in addition to code for primary procedure)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
22861	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
22862	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; lumbar	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
22867	Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level	Prior authorization is required and managed by EviCore. Reference policies for additional information.	HHO-DE-MP-1155 Interspinous and Interlaminar Stabilization/Distraction Devices	Prior authorization is managed by EviCore.
22868	Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; second level (List separately in addition to code for primary procedure)	Prior authorization is required and managed by EviCore. Reference policies for additional information.	HHO-DE-MP-1155 Interspinous and Interlaminar Stabilization/Distraction Devices	Prior authorization is managed by EviCore.
22869	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1155 Interspinous and Interlaminar Stabilization/Distraction Devices	
22870	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; second level (List separately in addition to code for primary procedure)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1155 Interspinous and Interlaminar Stabilization/Distraction Devices	
22899	Unlisted procedure, spine	Prior authorization is required for not otherwise classified codes. Reference policies for additional information.	HHO-DE-MP-1155 Interspinous and Interlaminar Stabilization/Distraction Devices	
23000	Removal of subdeltoid calcareous deposits, open	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
23020	Capsular contracture release (e.g., Sever type procedure)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
23120	Claviculectomy; partial	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.

23130	Acromioplasty or acromionectomy, partial, with or without coracoacromial ligament release	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
23410	Repair of ruptured musculotendinous cuff (e.g., rotator cuff) open; acute	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
23412	Repair of ruptured musculotendinous cuff (e.g., rotator cuff) open; chronic	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
23415	Coracoacromial ligament release, with or without acromioplasty	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
23420	Reconstruction of complete shoulder (rotator) cuff avulsion, chronic (includes acromioplasty)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
23430	Tenodesis of long tendon of biceps	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
23440	Resection or transplantation of long tendon of biceps	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
23450	Capsulorrhaphy, anterior; Putti-Platt procedure or Magnuson type operation	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
23455	Capsulorrhaphy, anterior; with labral repair (e.g., Bankart procedure)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
23460	Capsulorrhaphy, anterior, any type; with bone block	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
23462	Capsulorrhaphy, anterior, any type; with coracoid process transfer	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
23465	Capsulorrhaphy, glenohumeral joint, posterior, with or without bone block	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
23466	Capsulorrhaphy, glenohumeral joint, any type multi-directional instability	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
23470	Arthroplasty, glenohumeral joint; hemiarthroplasty	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
23472	Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (e.g., total shoulder))	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
23473	Revision of total shoulder arthroplasty, including allograft when performed; humeral or glenoid component	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
23474	Revision of total shoulder arthroplasty, including allograft when performed; humeral and glenoid component	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
23929	Unlisted procedure, shoulder	Prior authorization is required.		
24999	Unlisted procedure, humerus or elbow	Prior authorization is required.		
25999	Unlisted procedure, forearm or wrist	Prior authorization is required.		
26989	Unlisted procedure, hands or fingers	Prior authorization is required.		
27096	Injection procedure for sacroiliac joint, anesthetic/steroid, with image guidance (fluoroscopy or CT) including arthrography when performed	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
27125	Hemiarthroplasty, hip, partial (e.g., femoral stem prosthesis, bipolar arthroplasty)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
27130	Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
27132	Conversion of previous hip surgery to total hip arthroplasty, with or without autograft or allograft	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
27134	Revision of total hip arthroplasty; both components, with or without autograft or allograft	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
27137	Revision of total hip arthroplasty; acetabular component only, with or without autograft or allograft	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
27138	Revision of total hip arthroplasty; femoral component only, with or without allograft	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
27278	Arthrodesis, sacroiliac joint, percutaneous, with image guidance, includes placement of intra-articular implant(s)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
27279	Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed and placement of transfixing device	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
27280	Arthrodesis, open, sacroiliac joint, including obtaining bone graft, including instrumentation, when performed	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
27299	Unlisted procedure, pelvis or hip joint	Prior authorization is required.		
27332	Arthrotomy, with excision of semilunar cartilage (meniscectomy) knee; medial OR lateral	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
27333	Arthrotomy, with excision of semilunar cartilage (meniscectomy) knee; medial AND lateral	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
27334	Arthrotomy, with synovectomy, knee; anterior OR posterior	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
27335	Arthrotomy, with synovectomy, knee; anterior AND posterior including popliteal area	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
27403	Arthrotomy with meniscus repair, knee	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.

27405	Repair, primary, torn ligament and/or capsule, knee; collateral	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
27412	Autologous chondrocyte implantation, knee	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
27415	Osteochondral allograft, knee, open	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
27416	Osteochondral autograft(s), knee, open (e.g., mosaicplasty) (includes harvesting of autograft[s])	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
27418	Anterior tibial tubercleplasty (e.g., Maquet type procedure)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
27420	Reconstruction of dislocating patella; (e.g., Hauser type procedure)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
27422	Reconstruction of dislocating patella; with extensor realignment and/or muscle advancement or release (e.g., Campbell, Goldwaite type procedure)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
27424	Reconstruction of dislocating patella; with patellectomy	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
27425	Lateral retinacular release, open	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
27427	Ligamentous reconstruction (augmentation), knee; extra- articular	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
27428	Ligamentous reconstruction (augmentation), knee; intra-articular (open)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
27429	Ligamentous reconstruction (augmentation), knee; intra-articular (open) and extra-articular	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
27430	Quadricepsplasty (e.g., Bennett or Thompson type)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
27437	Arthroplasty, patella; without prosthesis	Prior authorization is required.		
27438	Arthroplasty, patella; with prosthesis	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
27440	Arthroplasty, knee, tibial plateau;	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
27441	Arthroplasty, knee, tibial plateau; with debridement and partial synovectomy	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
27442	Arthroplasty, femoral condyles or tibial plateau(s), knee;	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
27443	Arthroplasty, femoral condyles or tibial plateau(s), knee; with debridement and partial synovectomy	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
27445	Arthroplasty, knee, hinge prosthesis (eg, Walldius type)	Prior authorization is required.		
27446	Arthroplasty, knee, condyle and plateau; medial OR lateral compartment	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
27447	Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
27486	Revision of total knee arthroplasty, with or without allograft; 1 component	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
27487	Revision of total knee arthroplasty, with or without allograft; femoral and entire tibial component	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
27599	Procedure: Knee	Prior authorization is required.		
27899	Unlisted procedure, leg or ankle	Prior authorization is required.		
29799	Unlisted Casting/Strapping	Prior authorization is required.		
29800	Arthroscopy, temporomandibular joint, diagnostic, with or without synovial biopsy (separate procedure)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1136 Temporomandibular Joint Dysfunction	
29804	Arthroscopy, temporomandibular joint, surgical	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1136 Temporomandibular Joint Dysfunction	
29805	Arthroscopy, shoulder, diagnostic, with or without synovial biopsy (separate procedure)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
29806	Arthroscopy, shoulder, surgical; capsulorrhaphy	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
29807	Arthroscopy, shoulder, surgical; repair of SLAP lesion	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
29819	Arthroscopy, shoulder, surgical; with removal of loose body or foreign body	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
29820	Arthroscopy, shoulder, surgical; synovectomy, partial	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
29821	Arthroscopy, shoulder, surgical; synovectomy, complete	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
29822	Arthroscopy, shoulder, surgical; debridement, limited, 1 or 2 discrete structures (eg, humeral bone, humeral articular cartilage, glenoid bone, glenoid articular cartilage, biceps tendon, biceps anchor complex, labrum, articular capsule, articular side of the rotator cuff, bursal side of the rotator cuff, subacromial bursa, foreign body[ies])	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.

29823	Arthroscopy, shoulder, surgical; debridement, extensive, 3 or more discrete structures (eg, humeral bone, humeral articular cartilage, glenoid bone, glenoid articular cartilage, biceps tendon, biceps anchor complex, labrum, articular capsule, articular side of the rotator cuff, bursal side of the rotator cuff, subacromial bursa, foreign body[ies])	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
29824	Arthroscopy, shoulder, surgical; distal clavicullectomy including distal articular surface (Mumford procedure)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
29825	Arthroscopy, shoulder, surgical; with lysis and resection of adhesions, with or without manipulation	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
29826	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)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
29827	Arthroscopy, shoulder, surgical; with rotator cuff repair	Prior authorization is required through EviCore.		Prior authorization is managed by EviCore.
29828	Arthroscopy, shoulder, surgical; biceps tenodesis	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
29848	Endoscopy, wrist, surgical, with release of transverse carpal ligament	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1038 Carpal Tunnel	
29860	Arthroscopy, hip, diagnostic with or without synovial biopsy (separate procedure)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
29861	Arthroscopy, hip, surgical; with removal of loose body or foreign body	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
29862	Arthroscopy, hip, surgical; with debridement/shaving of articular cartilage (chondroplasty), abrasion arthroplasty and/or resection of labrum	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
29863	Arthroscopy, hip, surgical; with synovectomy	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
29866	Arthroscopy, knee, surgical; osteochondral autograft(s) (e.g., mosaicplasty) (includes harvesting of the autograft[s])	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
29867	Arthroscopy, knee, surgical; osteochondral allograft (e.g., mosaicplasty)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
29868	Arthroscopy, knee, surgical; meniscal transplantation (includes arthrotomy for meniscal insertion), medial or lateral	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
29870	Arthroscopy, knee, diagnostic, with or without synovial biopsy (separate procedure)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
29871	Arthroscopy, knee, surgical; for infection, lavage and drainage	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
29873	Arthroscopy, knee, surgical; with lateral release	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
29874	Arthroscopy, knee, surgical; for removal of loose body or foreign body (e.g., osteochondritis dissecans fragmentation, chondral fragmentation)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
29875	Arthroscopy, knee, surgical; synovectomy, limited (e.g., plica or shelf resection) (separate procedure)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
29876	Arthroscopy, knee, surgical; synovectomy, major, 2 or more compartments (e.g., medial or lateral)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
29877	Arthroscopy, knee, surgical; debridement/shaving of articular cartilage (chondroplasty)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
29879	Arthroscopy, knee, surgical; abrasion arthroplasty (includes chondroplasty where necessary) or multiple drilling or microfracture	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
29880	Arthroscopy, knee, surgical; with meniscectomy (medial AND lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
29881	Arthroscopy, knee, surgical; with meniscectomy (medial OR lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
29882	Arthroscopy, knee, surgical; with meniscus repair (medial OR lateral)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
29883	Arthroscopy, knee, surgical; with meniscus repair (medial AND lateral)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
29884	Arthroscopy, knee, surgical; with lysis of adhesions, with or without manipulation (separate procedure)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
29885	Arthroscopy, knee, surgical; drilling for osteochondritis dissecans with bone grafting, with or without internal fixation (including debridement of base of lesion)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
29886	Arthroscopy, knee, surgical; drilling for intact osteochondritis dissecans lesion	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
29887	Arthroscopy, knee, surgical; drilling for intact osteochondritis dissecans lesion with internal fixation	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
29888	Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
29889	Arthroscopically aided posterior cruciate ligament repair/augmentation or reconstruction	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
29914	Arthroscopy, hip, surgical; with femoroplasty (i.e., treatment of cam lesion)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.

29915	Arthroscopy, hip, surgical; with acetabuloplasty (i.e., treatment of pincer lesion)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
29916	Arthroscopy, hip, surgical; with labral repair	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
29999	Unlisted procedure, arthroscopy	Prior authorization is required for not otherwise classified codes.		
30130	Excision inferior turbinate, partial or complete, any method	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1064 Diagnosis and Treatment of Obstructive Sleep Apnea in Adults	
30140	Submucous resection inferior turbinate, partial or complete, any method	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1064 Diagnosis and Treatment of Obstructive Sleep Apnea in Adults	
30400	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service.		
30410	Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages and/or elevation of nasal tip	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service.		
30420	Rhinoplasty, primary; including major septal repair	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service.		
30430	Rhinoplasty, secondary; minor revision (small amount of nasal tip work)	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service.		
30435	Rhinoplasty, secondary; intermediate revision (bony work with osteotomies)	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service.		
30450	Rhinoplasty, secondary; major revision (nasal tip work and osteotomies)	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service.		
30460	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip only	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service.		
30462	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip, septum, osteotomies	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service.		
30465	Repair of nasal vestibular stenosis (eg, spreader grafting, lateral nasal wall reconstruction)	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service.		
30468	Repair of nasal valve collapse with subcutaneous/submucosal lateral wall implant(s)	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service.		
30520	Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service. Reference policies for additional information.	HHO-DE-MP-1137 Diagnosis and Treatment of Obstructive Sleep Apnea in Adults	
30540	Repair choanal atresia; intranasal	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service.		
30545	Repair choanal atresia; transpalatine	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service.		
30560	Lysis intranasal synechia	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service.		
30580	Repair fistula; oromaxillary (combine with 31030 if antrotomy is included)	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service.		
30600	Repair fistula; oronasal	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service.		
30620	Septal or other intranasal dermatoplasty (does not include obtaining graft)	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service.		
30630	Repair nasal septal perforations	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service.		
30999	Unlisted procedure: Nose	Prior authorization is required.		
31237	Nasal/sinus endoscopy, surgical; with biopsy, polypectomy or debridement (separate procedure)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1064 Diagnosis and Treatment of Obstructive Sleep Apnea in Adults	
31299	Unlisted procedure, accessory sinuses	Prior authorization is required.		
31599	Unlisted procedure: Larynx	Prior authorization is required.		
31600	Tracheostomy, planned (separate procedure);	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1064 Diagnosis and Treatment of Obstructive Sleep Apnea in Adults and HHO-DE-MP-1065 Diagnosis and Treatment of Obstructive Sleep Apnea in Pediatric Individuals	
31601	Tracheostomy, planned (separate procedure); younger than 2 years	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1064 Diagnosis and Treatment of Obstructive Sleep Apnea in Adults and HHO-DE-MP-1065 Diagnosis and Treatment of Obstructive Sleep Apnea in Pediatric Individuals	
31626	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of fiducial markers, single or multiple	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1230 Electromagnetic Navigational Bronchoscopy	
31627	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])	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1230 Electromagnetic Navigational Bronchoscopy	
31641	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)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1218 Radiofrequency Ablation of Miscellaneous Solid Tumors	
31899	Unlisted procedure, trachea, bronchi	Prior authorization is required.		
32664	Thoracoscopy, surgical; with thoracic sympathectomy	Prior authorization is required. Reference policies for additional information. DE-MP-1137 Hyperhidrosis		
32851	Lung transplant, single; without cardiopulmonary bypass	Prior authorization is required.		
32852	Lung transplant, single; with cardiopulmonary bypass	Prior authorization is required.		

32853	Lung transplant, double (bilateral sequential or en bloc); without cardiopulmonary bypass	Prior authorization is required.		
32854	Lung transplant, double (bilateral sequential or en bloc); with cardiopulmonary bypass	Prior authorization is required.		
32994	Ablation therapy for reduction or eradication of 1 or more pulmonary tumor(s) including pleura or chest wall when involved by tumor extension, percutaneous, including imaging guidance when performed, unilateral; cryoablation	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1218 Radiofrequency Ablation of Miscellaneous Solid Tumors	
32998	Ablation therapy for reduction or eradication of 1 or more pulmonary tumor(s) including pleura or chest wall when involved by tumor extension, percutaneous, including imaging guidance when performed, unilateral; radiofrequency	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1218 Radiofrequency Ablation of Miscellaneous Solid Tumors	
32999	Unlisted procedure, lungs and pleura	Prior authorization is required.		
33206	Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); atrial	Prior authorization is required.		
33207	Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); ventricular	Prior authorization is required.		
33208	Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); atrial and ventricular	Prior authorization is required.		
33212	Insertion of pacemaker pulse generator only; with existing single lead	Prior authorization is required.		
33213	Insertion of pacemaker pulse generator only; with existing dual leads	Prior authorization is required.		
33214	Upgrade of implanted pacemaker system, conversion of single chamber system to dual chamber system (includes removal of previously placed pulse generator, testing of existing lead, insertion of new lead, insertion of new generator)	Prior authorization is required.		
33221	Insertion of pacemaker pulse generator only; with existing multiple leads	Prior authorization is required.		
33224	Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, with attachment to previously placed pacemaker or pacing cardioverter-defibrillator pulse generator (including revision of pocket, removal, insertion, and/or replacement of existing generator)	Prior authorization is required.		
33225	Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, at time of insertion of pacing cardioverter-defibrillator or pacemaker pulse generator (including upgrade to dual chamber system and pocket revision) (list separately in addition to code for primary procedure)	Prior authorization is required.		
33227	Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; single lead system	Prior authorization is required.		
33228	Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; dual lead system	Prior authorization is required.		
33229	Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; multiple lead system	Prior authorization is required.		
33230	Insertion of pacing cardioverter-defibrillator pulse generator only; with existing dual leads	Prior authorization is required.		
33231	Insertion of pacing cardioverter-defibrillator pulse generator only; with existing multiple leads	Prior authorization is required.		
33240	Insertion of pacing cardioverter-defibrillator pulse generator only; with existing single lead	Prior authorization is required.		
33249	Insertion or replacement of permanent pacing cardioverter-defibrillator system with transvenous lead(s), single or dual chamber	Prior authorization is required.		
33250	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	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1187 Cardiac Ablation Procedure	
33251	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	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1187 Cardiac Ablation Procedure	
33254	Operative tissue ablation and reconstruction of atria, limited (eg, modified maze procedure)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1187 Cardiac Ablation Procedure	
33255	Operative tissue ablation and reconstruction of atria, extensive (eg, maze procedure); without cardiopulmonary bypass	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1187 Cardiac Ablation Procedure	
33256	Operative tissue ablation and reconstruction of atria, extensive (eg, maze procedure); with cardiopulmonary bypass	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1187 Cardiac Ablation Procedure	
33257	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)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1187 Cardiac Ablation Procedure	
33258	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)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1187 Cardiac Ablation Procedure	
33259	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)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1187 Cardiac Ablation Procedure	
33261	Operative ablation of ventricular arrhythmogenic focus with cardiopulmonary bypass	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1187 Cardiac Ablation Procedure	
33262	Removal of pacing cardioverter-defibrillator pulse generator with replacement of pacing cardioverter-defibrillator pulse generator; single lead system	Prior authorization is required.		
33263	Removal of pacing cardioverter-defibrillator pulse generator with replacement of pacing cardioverter-defibrillator pulse generator; dual lead system	Prior authorization is required.		
33264	Removal of pacing cardioverter-defibrillator pulse generator with replacement of pacing cardioverter-defibrillator pulse generator; multiple lead system	Prior authorization is required.		

33265	Endoscopy, surgical; operative tissue ablation and reconstruction of atria, limited (eg, modified maze procedure), without cardiopulmonary bypass	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1187 Cardiac Ablation Procedure	
33266	Endoscopy, surgical; operative tissue ablation and reconstruction of atria, extensive (eg, maze procedure), without cardiopulmonary bypass	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1187 Cardiac Ablation Procedure	
33270	Insertion or replacement of permanent subcutaneous implantable defibrillator system, with subcutaneous electrode, including defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing for arrhythmia termination, and programming or reprogramming of sensing or therapeutic parameters, when performed	Prior authorization is required.		
33274	Transcatheter insertion or replacement of permanent leadless pacemaker, right ventricular, including imaging guidance (eg, fluoroscopy, venous ultrasound, ventriculography, femoral venography) and device evaluation (eg, interrogation or programming), when performed	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
33275	Transcatheter removal of permanent leadless pacemaker, right ventricular	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
33289	Transcatheter implantation of wireless pulmonary artery pressure sensor for long-term hemodynamic monitoring, including deployment and calibration of the sensor, right heart catheterization, selective pulmonary catheterization, radiological supervision and interpretation and pulmonary artery angiography, when performed	Prior authorization is managed by EviCore. Reference policies for additional information.		Prior authorization is managed by EviCore.
33340	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	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1151 Percutaneous Left Atrial Appendage Closure (LAAC) Device	
33361	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; percutaneous femoral artery approach	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1125 Transcatheter Aortic Valve Replacement	
33362	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open femoral artery approach	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1125 Transcatheter Aortic Valve Replacement	
33363	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open axillary artery approach	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1125 Transcatheter Aortic Valve Replacement	
33364	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open iliac artery approach	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1125 Transcatheter Aortic Valve Replacement	
33365	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transaortic approach (eg, median sternotomy, mediastinotomy)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1125 Transcatheter Aortic Valve Replacement	
33366	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transapical exposure (eg, left thoracotomy)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1125 Transcatheter Aortic Valve Replacement	
33367	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)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1125 Transcatheter Aortic Valve Replacement	
33368	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)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1125 Transcatheter Aortic Valve Replacement	
33369	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)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1125 Transcatheter Aortic Valve Replacement	
33370	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)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1125 Transcatheter Aortic Valve Replacement	
33418	Transcatheter mitral valve repair, percutaneous approach, including transseptal puncture when performed; initial prosthesis	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1126 Transcatheter Mitral Valve Repair/Replacement	
33419	Transcatheter mitral valve repair, percutaneous approach, including transseptal puncture when performed; additional prosthesis(es) during same session (List separately in addition to code for primary procedure)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1126 Transcatheter Mitral Valve Repair/Replacement	
33477	Transcatheter pulmonary valve implantation, percutaneous approach, including pre-stenting of the valve delivery site, when performed	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1022 Transcatheter Pulmonary Valve Implantation	
33880	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	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1157 Endovascular/Endoluminal Stent Grafts	
33881	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	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1157 Endovascular/Endoluminal Stent Grafts	
33883	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	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1157 Endovascular/Endoluminal Stent Grafts	
33884	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)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1157 Endovascular/Endoluminal Stent Grafts	

33886	Placement of distal extension prosthesis(s) delayed after endovascular repair of descending thoracic aorta	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1157 Endovascular/Endoluminal Stent Grafts	
33889	Open subclavian to carotid artery transposition performed in conjunction with endovascular repair of descending thoracic aorta, by neck incision, unilateral	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1157 Endovascular/Endoluminal Stent Grafts	
33891	Bypass graft, with other than vein, transcervical retropharyngeal carotid-carotid, performed in conjunction with endovascular repair of descending thoracic aorta, by neck incision	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1157 Endovascular/Endoluminal Stent Grafts	
33927	Implantation of a total replacement heart system (artificial heart) with recipient cardiectomy	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1104 Artificial Hearts and Ventricular Assist Devices	
33928	Removal and replacement of total replacement heart system (artificial heart)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1104 Artificial Hearts and Ventricular Assist Devices	
33929	Removal of a total replacement heart system (artificial heart) for heart transplantation (List separately in addition to code for primary procedure)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1104 Artificial Hearts and Ventricular Assist Devices	
33935	Heart-lung transplant with recipient cardiectomy-pneumonectomy	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1108 Heart/Lung Transplant	
33945	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	Prior authorization is required.		
33946	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; initiation, veno-venous	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1061 Extracorporeal Membrane Oxygenation (ECMO)	
33947	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; initiation, veno-arterial	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1061 Extracorporeal Membrane Oxygenation (ECMO)	
33948	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; daily management, each day, veno-venous	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1061 Extracorporeal Membrane Oxygenation (ECMO)	
33949	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; daily management, each day, veno-arterial	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1061 Extracorporeal Membrane Oxygenation (ECMO)	
33951	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)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1061 Extracorporeal Membrane Oxygenation (ECMO)	
33953	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	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1061 Extracorporeal Membrane Oxygenation (ECMO)	
33954	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	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1061 Extracorporeal Membrane Oxygenation (ECMO)	
33955	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	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1061 Extracorporeal Membrane Oxygenation (ECMO)	
33956	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; insertion of central cannula(e) by sternotomy or thoracotomy, 6 years and older	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1061 Extracorporeal Membrane Oxygenation (ECMO)	
33957	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)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1061 Extracorporeal Membrane Oxygenation (ECMO)	
33958	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)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1061 Extracorporeal Membrane Oxygenation (ECMO)	
33959	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)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1061 Extracorporeal Membrane Oxygenation (ECMO)	
33962	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)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1061 Extracorporeal Membrane Oxygenation (ECMO)	
33963	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)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1061 Extracorporeal Membrane Oxygenation (ECMO)	
33964	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)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1061 Extracorporeal Membrane Oxygenation (ECMO)	
33965	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	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1061 Extracorporeal Membrane Oxygenation (ECMO)	
33966	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	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1061 Extracorporeal Membrane Oxygenation (ECMO)	
33969	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	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1061 Extracorporeal Membrane Oxygenation (ECMO)	
33975	Insertion of ventricular assist device; extracorporeal, single ventricle	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1104 Artificial Hearts and Ventricular Assist Devices	

33976	Insertion of ventricular assist device; extracorporeal, biventricular	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1104 Artificial Hearts and Ventricular Assist Devices	
33977	Removal of ventricular assist device; extracorporeal, single ventricle	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1104 Artificial Hearts and Ventricular Assist Devices	
33978	Removal of ventricular assist device; extracorporeal, biventricular	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1104 Artificial Hearts and Ventricular Assist Devices	
33979	Insertion of ventricular assist device, implantable intracorporeal, single ventricle	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1104 Artificial Hearts and Ventricular Assist Devices	
33980	Removal of ventricular assist device, implantable intracorporeal, single ventricle	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1104 Artificial Hearts and Ventricular Assist Devices	
33981	Replacement of extracorporeal ventricular assist device, single or biventricular, pump(s), single or each pump	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1104 Artificial Hearts and Ventricular Assist Devices	
33982	Replacement of ventricular assist device pump(s); implantable intracorporeal, single ventricle, without cardiopulmonary bypass	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1104 Artificial Hearts and Ventricular Assist Devices	
33983	Replacement of ventricular assist device pump(s); implantable intracorporeal, single ventricle, with cardiopulmonary bypass	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1104 Artificial Hearts and Ventricular Assist Devices	
33984	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	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1061 Extracorporeal Membrane Oxygenation (ECMO)	
33985	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	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1061 Extracorporeal Membrane Oxygenation (ECMO)	
33986	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; removal of central cannula(e) by sternotomy or thoracotomy, 6 years and older	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1061 Extracorporeal Membrane Oxygenation (ECMO)	
33987	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)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1061 Extracorporeal Membrane Oxygenation (ECMO)	
33988	Insertion of left heart vent by thoracic incision (eg, sternotomy, thoracotomy) for ECMO/ECLS	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1061 Extracorporeal Membrane Oxygenation (ECMO)	
33989	Removal of left heart vent by thoracic incision (eg, sternotomy, thoracotomy) for ECMO/ECLS	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1061 Extracorporeal Membrane Oxygenation (ECMO)	
33990	Insertion of ventricular assist device, percutaneous, including radiological supervision and interpretation; left heart, arterial access only	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1104 Artificial Hearts and Ventricular Assist Devices	
33991	Insertion of ventricular assist device, percutaneous, including radiological supervision and interpretation; left heart, both arterial and venous access, with transseptal puncture	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1104 Artificial Hearts and Ventricular Assist Devices	
33992	Removal of percutaneous left heart ventricular assist device, arterial or arterial and venous cannula(s), at separate and distinct session from insertion	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1104 Artificial Hearts and Ventricular Assist Devices	
33993	Repositioning of percutaneous right or left heart ventricular assist device with imaging guidance at separate and distinct session from insertion	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1104 Artificial Hearts and Ventricular Assist Devices	
33995	Insertion of ventricular assist device, percutaneous, including radiological supervision and interpretation; right heart, venous access only	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1104 Artificial Hearts and Ventricular Assist Devices	
33997	Removal of percutaneous right heart ventricular assist device, venous cannula, at separate and distinct session from insertion	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1104 Artificial Hearts and Ventricular Assist Devices	
33999	Unlisted procedure, cardiac surgery	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1104 Artificial Hearts and Ventricular Assist Devices	
34706	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)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1157 Endovascular/Endoluminal Stent Grafts	
34707	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)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1157 Endovascular/Endoluminal Stent Grafts	
34708	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)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1157 Endovascular/Endoluminal Stent Grafts	
34709	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)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1157 Endovascular/Endoluminal Stent Grafts	

34710	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	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1157 Endovascular/Endoluminal Stent Grafts	
34711	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)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1157 Endovascular/Endoluminal Stent Grafts	
34712	Transcatheter delivery of enhanced fixation device(s) to the endograft (eg, anchor, screw, tack) and all associated radiological supervision and interpretation	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1157 Endovascular/Endoluminal Stent Grafts	
34713	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)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1157 Endovascular/Endoluminal Stent Grafts	
34714	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)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1157 Endovascular/Endoluminal Stent Grafts	
34715	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)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1157 Endovascular/Endoluminal Stent Grafts	
34716	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)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1157 Endovascular/Endoluminal Stent Grafts	
34808	Endovascular placement of iliac artery occlusion device (List separately in addition to code for primary procedure)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1157 Endovascular/Endoluminal Stent Grafts	
34813	Placement of femoral-femoral prosthetic graft during endovascular aortic aneurysm repair (List separately in addition to code for primary procedure)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1157 Endovascular/Endoluminal Stent Grafts	
34830	Open repair of infrarenal aortic aneurysm or dissection, plus repair of associated arterial trauma, following unsuccessful endovascular repair; tube prosthesis	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1157 Endovascular/Endoluminal Stent Grafts	
34831	Open repair of infrarenal aortic aneurysm or dissection, plus repair of associated arterial trauma, following unsuccessful endovascular repair; aorto-bi-iliac prosthesis	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1157 Endovascular/Endoluminal Stent Grafts	
34841	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)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1157 Endovascular/Endoluminal Stent Grafts	
34842	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])	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1157 Endovascular/Endoluminal Stent Grafts	
34843	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])	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1157 Endovascular/Endoluminal Stent Grafts	
34844	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])	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1157 Endovascular/Endoluminal Stent Grafts	
34845	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)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1157 Endovascular/Endoluminal Stent Grafts	
34846	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])	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1157 Endovascular/Endoluminal Stent Grafts	
34847	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])	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1157 Endovascular/Endoluminal Stent Grafts	

34848	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])	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1157 Endovascular/Endoluminal Stent Grafts	
36228	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)	Prior authorization is required.		
36245	Selective catheter placement, arterial system; each first order abdominal, pelvic, or lower extremity artery branch, within a vascular family	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1156 Treatment of Abnormal Uterine Bleeding and Fibroids	
36246	Selective catheter placement, arterial system; initial second order abdominal, pelvic, or lower extremity artery branch, within a vascular family	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1156 Treatment of Abnormal Uterine Bleeding and Fibroids	
36247	Selective catheter placement, arterial system; initial third order or more selective abdominal, pelvic, or lower extremity artery branch, within a vascular family	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1156 Treatment of Abnormal Uterine Bleeding and Fibroids	
36248	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)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1156 Treatment of Abnormal Uterine Bleeding and Fibroids	
36299	Unlisted Procedure: Vascular injection	Prior authorization is required.		
36465	Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance and monitoring; single incompetent extremity truncal vein (eg, great saphenous vein, accessory saphenous vein)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1100 Surgical Treatment of Varicose Veins	
36466	Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance and monitoring; multiple incompetent truncal veins (eg, great saphenous vein, accessory saphenous vein), same leg	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1100 Surgical Treatment of Varicose Veins	
36468	Injection(s) of sclerosant for spider veins (telangiectasia), limb or trunk	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1100 Surgical Treatment of Varicose Veins	
36470	Injection of sclerosant; single incompetent vein (other than telangiectasia)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1100 Surgical Treatment of Varicose Veins	
36471	Injection of sclerosant; multiple incompetent veins (other than telangiectasia), same leg	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1100 Surgical Treatment of Varicose Veins	
36473	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; first vein treated	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1100 Surgical Treatment of Varicose Veins	
36474	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1100 Surgical Treatment of Varicose Veins	
36475	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1100 Surgical Treatment of Varicose Veins	
36476	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1100 Surgical Treatment of Varicose Veins	
36478	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1100 Surgical Treatment of Varicose Veins	
36479	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1100 Surgical Treatment of Varicose Veins	
36482	Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; first vein treated	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1100 Surgical Treatment of Varicose Veins	
36483	Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1100 Surgical Treatment of Varicose Veins	
36511	Therapeutic apheresis; for white blood cells	Prior authorization is required.		
36901	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;	Prior authorization is required.		

36902	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	Prior authorization is required.		
36903	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	Prior authorization is required.		
36904	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);	Prior authorization is required.		
36905	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	Prior authorization is required.		
36906	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	Prior authorization is required.		
36907	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)	Prior authorization is required.		
36908	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)	Prior authorization is required.		
36909	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)	Prior authorization is required.		
37211	Transcatheter therapy, arterial infusion for thrombolysis other than coronary or intracranial, any method, including radiological supervision and interpretation, initial treatment day	Prior authorization is required.		
37212	Transcatheter therapy, venous infusion for thrombolysis, any method, including radiological supervision and interpretation, initial treatment day	Prior authorization is required.		
37213	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;	Prior authorization is required.		
37214	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	Prior authorization is required.		
37215	Transcatheter placement of intravascular stent(s), cervical carotid artery, open or percutaneous, including angioplasty, when performed and radiological supervision and interpretation; with distal embolic protection	Prior authorization is required.		
37216	Transcatheter placement of intravascular stent(s), cervical carotid artery, open or percutaneous, including angioplasty, when performed and radiological supervision and interpretation; without distal embolic protection	Prior authorization is required.		
37218	Transcatheter placement of intravascular stent(s), intrathoracic common carotid artery or innominate artery, open or percutaneous antegrade approach, including angioplasty, when performed and radiological supervision and interpretation	Prior authorization is required.		
37236	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	Prior authorization is required.		

37237	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)	Prior authorization is required.		
37243	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping and imaging guidance necessary to complete the intervention; for tumors, organ ischemia, or infarction	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1156 Treatment of Abnormal Uterine Bleeding and Fibroids and HHO-DE-MP-1158 Treatment of Prostate	
37244	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1156 Treatment of Abnormal Uterine Bleeding and Fibroids	
37246	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	Prior authorization is required.		
37247	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)	Prior authorization is required.		
37500	Vascular endoscopy, surgical, with ligation of perforator veins, subfascial (SEPS)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1100 Surgical Treatment of Varicose Veins	
37501	Unlisted vascular endoscopy procedure	Prior authorization is required.		
37700	Ligation and division of long saphenous vein at saphenofemoral junction, or distal interruptions	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1100 Surgical Treatment of Varicose Veins	
37718	Ligation, division and stripping, short saphenous vein	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1100 Surgical Treatment of Varicose Veins	
37722	Ligation, division and stripping, long (greater) saphenous veins from saphenofemoral junction to knee or below	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1100 Surgical Treatment of Varicose Veins	
37735	Ligation and division and complete stripping of long or short saphenous veins with radical excision of ulcer and skin graft and/or interruption of communicating veins of lower leg, with excision of deep fascia	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1100 Surgical Treatment of Varicose Veins	
37760	Ligation of perforator veins, subfascial, radical (Linton type), including skin graft, when performed, open,1 leg	Prior authorization is required.		
37761	Ligation of perforator vein(s), subfascial, open, including ultrasound guidance, when performed, 1 leg	Prior authorization is required.		
37765	Stab phlebectomy of varicose veins, 1 extremity; 10-20 stab incisions	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1100 Surgical Treatment of Varicose Veins	
37766	Stab phlebectomy of varicose veins, 1 extremity; more than 20 incisions	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1100 Surgical Treatment of Varicose Veins	
37780	Ligation and division of short saphenous vein at saphenopopliteal junction (separate procedure)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1100 Surgical Treatment of Varicose Veins	
37785	Ligation, division and/or excision of varicose vein cluster(s), 1 leg	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1100 Surgical Treatment of Varicose Veins	
37799	Unlisted procedure, vascular surgery	Prior authorization is required. Reference policies for additional information. Prior authorization is required for not otherwise classified codes.	HHO-DE-MP-1157 Endovascular/Endoluminal Stent Grafts and HHO-DE-MP-1100 Surgical Treatment of Varicose Veins	
38129	Unlisted laparoscopy procedure, spleen	Prior authorization is required.		
38206	Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; autologous	Prior authorization is required. Reference policies for additional information.	Hematopoietic Cell Transplantation in Treatment of Germ-Cell Tumors HHO-DE-MP-1119, Hematopoietic Cell Transplantation in Waldenstrom Macroglobulinemia HHO-DE-MP-1121, Orthopedic Applications of Stem-Cell Therapy HHO-DE-MP-1122, Hematopoietic Cell Transplantation (HCT) for Autoimmune Diseases HHO-DE-MP-1103, Hematopoietic Cell Transplantation for CNS Embryonal Tumors and Ependymoma HHO-DE-MP-1107, Hematopoietic Cell Transplantation for Solid Tumors of Childhood Surgery HHO-DE-MP-1118	
38230	Bone marrow harvesting for transplantation; allogeneic	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1122 Orthopedic Applications of Stem-Cell Therapy, HHO-DE-MP-1121 Hematopoietic Cell Transplantation in Waldenstrom Macroglobulinemia, HHO-DE-MP-1118 Hematopoietic Cell Transplantation for Solid Tumors of Childhood Surgery, HHO-DE-MP-1113 Hematopoietic Cell Transplantation from Chronic Myeloid Leukemia, HHO-DE-MP-1107 Hematopoietic Cell Transplantation for CNS Embryonal Tumors and Ependymoma, HHO-DE-MP-1103 Hematopoietic Cell Transplantation (HCT) for Autoimmune Diseases, or HHO-DE-MP-1098 Allogeneic Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemia	

38232	Bone marrow harvesting for transplantation; autologous	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1122 Orthopedic Applications of Stem-Cell Therapy, HHO-DE-MP-1121 Hematopoietic Cell Transplantation in Waldenstrom Macroglobulinemia, HHO-DE-MP-1118 Hematopoietic Cell Transplantation for Solid Tumors of Childhood Surgery , HHO-DE-MP-1107 Hematopoietic Cell Transplantation for CNS Embryonal Tumors and Ependymoma, or HHO-DE-MP-1103 Hematopoietic Cell Transplantation (HCT) for Autoimmune Diseases	
38240	Hematopoietic progenitor cell (HPC); allogeneic transplantation per donor	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1098 Allogeneic Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemia and HHO-DE-MP-110 Hematopoietic Cell Transplantation (HCT) for Autoimmune Diseases and HHO-DE-MP-1107 Hematopoietic Cell Transplantation for CNS Embryonal Tumors and Ependymoma and HHO-DE-MP-1113 Hematopoietic Cell Transplantation from Chronic Myeloid Leukemia and HHO-DE-MP-1118 Hematopoietic Cell Transplantation for Solid Tumors of Childhood Surgery and HHO-DE-MP-1119 Hematopoietic Cell Transplantation in Treatment of Germ-Cell Tumors and HHO-DE-MP-1121 Hematopoietic Cell Transplantation in Waldenstrom Macroglobulinemia	
38241	Hematopoietic progenitor cell (HPC); autologous transplantation	Prior authorization is required. Reference policies for additional information.	Hematopoietic Cell Transplantation in Treatment of Germ-Cell Tumors HHO-DE-MP-1119, Hematopoietic Cell Transplantation in Waldenstrom Macroglobulinemia HHO-DE-MP-1121, Orthopedic Applications of Stem-Cell Therapy HHO-DE-MP-1122, Hematopoietic Cell Transplantation (HCT) for Autoimmune Diseases HHO-DE-MP-1103, Hematopoietic Cell Transplantation for CNS Embryonal Tumors and Ependymoma HHO-DE-MP-1107, Hematopoietic Cell Transplantation from Chronic Myeloid Leukemia HHO-DE-MP-1113, or Hematopoietic Cell Transplantation for Solid Tumors of Childhood Surgery HHO-DE-MP-1118	
38242	Allogeneic lymphocyte infusions	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1118 Hematopoietic Cell Transplantation for Solid Tumors of Childhood Surgery	
38589	Unlisted laparoscopy procedure, lymphatic system	Prior authorization is required.		
38999	Procedure: Hemic or lymphatic system	Prior authorization is required.		
39499	Unlisted procedure, mediastinum	Prior authorization is required.		
39599	Unlisted procedure, diaphragm	Prior authorization is required.		
40799	Procedure: Lips	Prior authorization is required.		
40899	Unlisted procedure, vestibule of mouth	Prior authorization is required.		
41120	Glossectomy; less than one-half tongue	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1064 Diagnosis and Treatment of Obstructive Sleep Apnea in Adults	
41130	Glossectomy; hemiglossectomy	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1064 Diagnosis and Treatment of Obstructive Sleep Apnea in Adults	
41512	Frenoplasty (surgical revision of frenum, eg, with Z-plasty)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1064 Diagnosis and Treatment of Obstructive Sleep Apnea in Adults and HHO-DE-MP-1065 Diagnosis and Treatment of Obstructive Sleep Apnea in Pediatric Individuals	
41530	Submucosal ablation of the tongue base, radiofrequency, 1 or more sites, per session	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1064 Diagnosis and Treatment of Obstructive Sleep Apnea in Adults and HHO-DE-MP-1065 Diagnosis and Treatment of Obstructive Sleep Apnea in Pediatric Individuals	
41599	Unlisted procedure, tongue, floor of mouth	Prior authorization is required.		
41899	Procedure: Dentoalveolar structure	Prior authorization is required.	HHO-DE-RP-1004 Dental Services Under the Medical Benefit	
42140	Uvulectomy, excision of uvula	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1064 Diagnosis and Treatment of Obstructive Sleep Apnea in Adults and HHO-DE-MP-1065 Diagnosis and Treatment of Obstructive Sleep Apnea in Pediatric Individuals	
42145	Palatopharyngoplasty (eg, uvulopalatopharyngoplasty, uvulopharyngoplasty)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1064 Diagnosis and Treatment of Obstructive Sleep Apnea in Adults and HHO-DE-MP-1065 Diagnosis and Treatment of Obstructive Sleep Apnea in Pediatric Individuals	
42299	Unlisted procedure, palate, uvula	Prior authorization is required. Reference policies for additional information. Prior authorization is required for not otherwise classified codes.	HHO-DE-MP-1064 Diagnosis and Treatment of Obstructive Sleep Apnea in Adults	
42699	Unlisted procedure, salivary glands or ducts	Prior authorization is required.		

42820	Tonsillectomy and adenoidectomy; younger than age 12	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1064 Diagnosis and Treatment of Obstructive Sleep Apnea in Adults and HHO-DE-MP-1065 Diagnosis and Treatment of Obstructive Sleep Apnea in Pediatric Individuals	
42821	Tonsillectomy and adenoidectomy; age 12 or over	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1064 Diagnosis and Treatment of Obstructive Sleep Apnea in Adults and HHO-DE-MP-1065 Diagnosis and Treatment of Obstructive Sleep Apnea in Pediatric Individuals	
42825	Tonsillectomy, primary or secondary; younger than age 12	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1064 Diagnosis and Treatment of Obstructive Sleep Apnea in Adults and HHO-DE-MP-1065 Diagnosis and Treatment of Obstructive Sleep Apnea in Pediatric Individuals	
42826	Tonsillectomy, primary or secondary; age 12 or over	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1064 Diagnosis and Treatment of Obstructive Sleep Apnea in Adults and HHO-DE-MP-1065 Diagnosis and Treatment of Obstructive Sleep Apnea in Pediatric Individuals	
42830	Adenoidectomy, primary; younger than age 12	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1064 Diagnosis and Treatment of Obstructive Sleep Apnea in Adults and HHO-DE-MP-1065 Diagnosis and Treatment of Obstructive Sleep Apnea in Pediatric Individuals	
42831	Adenoidectomy, primary; age 12 or over	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1064 Diagnosis and Treatment of Obstructive Sleep Apnea in Adults and HHO-DE-MP-1065 Diagnosis and Treatment of Obstructive Sleep Apnea in Pediatric Individuals	
42835	Adenoidectomy, secondary; younger than age 12	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1064 Diagnosis and Treatment of Obstructive Sleep Apnea in Adults and HHO-DE-MP-1065 Diagnosis and Treatment of Obstructive Sleep Apnea in Pediatric Individuals	
42836	Adenoidectomy, secondary; age 12 or over	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1064 Diagnosis and Treatment of Obstructive Sleep Apnea in Adults and HHO-DE-MP-1065 Diagnosis and Treatment of Obstructive Sleep Apnea in Pediatric Individuals	
42999	Unlisted procedure, pharynx, adenoids, or tonsils	Prior authorization is required. Reference policies for additional information. Prior authorization is required for not otherwise classified codes.	HHO-DE-MP-1064 Diagnosis and Treatment of Obstructive Sleep Apnea in Adults	
43192	Esophagoscopy, rigid, transoral; with directed submucosal injection(s), any substance	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1139 Transesophageal Endoscopic Therapies for Gastroesophageal Reflux Disease	
43201	Esophagoscopy, flexible, transoral; with directed submucosal injection(s), any substance	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1139 Transesophageal Endoscopic Therapies for Gastroesophageal Reflux Disease	
43210	Esophagogastroduodenoscopy, flexible, transoral; with esophagogastric fundoplasty, partial or complete, includes duodenoscopy when performed	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1139 Transesophageal Endoscopic Therapies for Gastroesophageal Reflux Disease	
43212	Esophagoscopy, flexible, transoral; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1139 Transesophageal Endoscopic Therapies for Gastroesophageal Reflux Disease	
43240	Esophagogastroduodenoscopy, flexible, transoral; with transmural drainage of pseudocyst (includes placement of transmural drainage catheter[s]/stent[s], when performed and endoscopic ultrasound, when performed)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1217 Upper Gastrointestinal Endoscopy (EGD)	
43241	Esophagogastroduodenoscopy, flexible, transoral; with insertion of intraluminal tube or catheter	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1217 Upper Gastrointestinal Endoscopy (EGD)	
43242	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)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1217 Upper Gastrointestinal Endoscopy (EGD)	
43243	Esophagogastroduodenoscopy, flexible, transoral; with injection sclerosis of esophageal/gastric varices	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1217 Upper Gastrointestinal Endoscopy (EGD)	
43244	Esophagogastroduodenoscopy, flexible, transoral; with band ligation of esophageal/gastric varices	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1217 Upper Gastrointestinal Endoscopy (EGD)	
43245	Esophagogastroduodenoscopy, flexible, transoral; with dilation of gastric/duodenal stricture(s) (eg, balloon, bougie)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1217 Upper Gastrointestinal Endoscopy (EGD)	
43246	Esophagogastroduodenoscopy, flexible, transoral; with directed placement of percutaneous gastrostomy tube	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1217 Upper Gastrointestinal Endoscopy (EGD)	
43247	Esophagogastroduodenoscopy, flexible, transoral; with removal of foreign body(s)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1217 Upper Gastrointestinal Endoscopy (EGD)	
43249	Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic balloon dilation of esophagus (less than 30 mm diameter)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1217 Upper Gastrointestinal Endoscopy (EGD)	
43250	Esophagogastroduodenoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1217 Upper Gastrointestinal Endoscopy (EGD)	
43251	Esophagogastroduodenoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1217 Upper Gastrointestinal Endoscopy (EGD)	
43252	Esophagogastroduodenoscopy, flexible, transoral; with optical endomicroscopy	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1217 Upper Gastrointestinal Endoscopy (EGD)	

43253	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)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1139 Transesophageal Endoscopic Therapies for Gastroesophageal Reflux Disease and HHO-DE-MP-1217 Upper Gastrointestinal Endoscopy (EGD)	
43254	Esophagogastroduodenoscopy, flexible, transoral; with endoscopic mucosal resection	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1217 Upper Gastrointestinal Endoscopy (EGD)	
43255	Esophagogastroduodenoscopy, flexible, transoral; with control of bleeding, any method	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1217 Upper Gastrointestinal Endoscopy (EGD)	
43257	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	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1139 Transesophageal Endoscopic Therapies for Gastroesophageal Reflux Disease and HHO-DE-MP-1217 Upper Gastrointestinal Endoscopy (EGD)	
43259	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	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1217 Upper Gastrointestinal Endoscopy (EGD)	
43260	Endoscopic retrograde cholangiopancreatography (ERCP); diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1217 Upper Gastrointestinal Endoscopy (EGD)	
43261	Endoscopic retrograde cholangiopancreatography (ERCP); with biopsy, single or multiple	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1217 Upper Gastrointestinal Endoscopy (EGD)	
43262	Endoscopic retrograde cholangiopancreatography (ERCP); with sphincterotomy/papillotomy	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1217 Upper Gastrointestinal Endoscopy (EGD)	
43263	Endoscopic retrograde cholangiopancreatography (ERCP); with pressure measurement of sphincter of Oddi	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1217 Upper Gastrointestinal Endoscopy (EGD)	
43264	Endoscopic retrograde cholangiopancreatography (ERCP); with removal of calculi/debris from biliary/pancreatic duct(s)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1217 Upper Gastrointestinal Endoscopy (EGD)	
43265	Endoscopic retrograde cholangiopancreatography (ERCP); with destruction of calculi, any method (eg, mechanical, electrohydraulic, lithotripsy)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1217 Upper Gastrointestinal Endoscopy (EGD)	
43266	Esophagogastroduodenoscopy, flexible, transoral; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1139 Transesophageal Endoscopic Therapies for Gastroesophageal Reflux Disease and HHO-DE-MP-1217 Upper Gastrointestinal Endoscopy (EGD)	
43270	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)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1217 Upper Gastrointestinal Endoscopy (EGD)	
43274	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	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1217 Upper Gastrointestinal Endoscopy (EGD)	
43275	Endoscopic retrograde cholangiopancreatography (ERCP); with removal of foreign body(s) or stent(s) from biliary/pancreatic duct(s)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1217 Upper Gastrointestinal Endoscopy (EGD)	
43276	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	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1217 Upper Gastrointestinal Endoscopy (EGD)	
43277	Endoscopic retrograde cholangiopancreatography (ERCP); with trans-endoscopic balloon dilation of biliary/pancreatic duct(s) or of ampulla (sphincteroplasty), including sphincterotomy, when performed, each duct	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1217 Upper Gastrointestinal Endoscopy (EGD)	
43278	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	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1217 Upper Gastrointestinal Endoscopy (EGD)	
43284	Laparoscopy, surgical, esophageal sphincter augmentation procedure, placement of sphincter augmentation device (ie, magnetic band), including cruroplasty when performed	Prior authorization is required.		
43285	Removal of esophageal sphincter augmentation device	Prior authorization is required.		
43289	Unlisted laparoscopy procedure, esophagus	Prior authorization is required for not otherwise classified codes.		
43499	Unlisted procedure, esophagus	Prior authorization is required. Reference policies for additional information. Prior authorization is required for not otherwise classified codes.	HHO-DE-MP-1139 Transesophageal Endoscopic Therapies for Gastroesophageal Reflux Disease	
43640	Vagotomy including pyloroplasty, with or without gastrostomy; truncal or selective	Prior authorization is required.		
43641	Vagotomy including pyloroplasty, with or without gastrostomy; parietal cell (highly selective)	Prior authorization is required.		
43644	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1004 Bariatric Surgery	
43645	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and small intestine reconstruction to limit absorption	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1004 Bariatric Surgery	
43647	Laparoscopy, surgical; implantation or replacement of gastric neurostimulator electrodes, antrum	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1235 Gastric Electrical Stimulation and Gastric Pacing	
43648	Laparoscopy, surgical; revision or removal of gastric neurostimulator electrodes, antrum	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1235 Gastric Electrical Stimulation and Gastric Pacing	
43651	Laparoscopy, surgical; transection of vagus nerves, truncal	Prior authorization is required.		
43652	Laparoscopy, surgical; transection of vagus nerves, selective or highly selective	Prior authorization is required.		
43659	Unlisted laparoscopy procedure, stomach	Prior authorization is required for not otherwise classified codes. Reference policies for additional information.	HHO-DE-MP-1139 Transesophageal Endoscopic Therapies for Gastroesophageal Reflux Disease	
43770	Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric restrictive device (eg, gastric band and subcutaneous port components)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1004 Bariatric Surgery	
43771	Laparoscopy, surgical, gastric restrictive procedure; revision of adjustable gastric restrictive device component only	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1004 Bariatric Surgery	

43772	Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device component only	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1004 Bariatric Surgery	
43773	Laparoscopy, surgical, gastric restrictive procedure; removal and replacement of adjustable gastric restrictive device component only	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1004 Bariatric Surgery	
43774	Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device and subcutaneous port components	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1004 Bariatric Surgery	
43775	Laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy (ie, sleeve gastrectomy)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1004 Bariatric Surgery	
43842	Gastric restrictive procedure, without gastric bypass, for morbid obesity; vertical-banded gastroplasty	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1004 Bariatric Surgery	
43843	Gastric restrictive procedure, without gastric bypass, for morbid obesity; other than vertical-banded gastroplasty	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1004 Bariatric Surgery	
43845	Gastric restrictive procedure with partial gastrectomy, pylorus-preserving duodenoileostomy and ileoileostomy (50 to 100 cm common channel) to limit absorption (biliopancreatic diversion with duodenal switch)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1004 Bariatric Surgery	
43846	Gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb (150 cm or less) Roux-en-Y gastroenterostomy	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1004 Bariatric Surgery	
43847	Gastric restrictive procedure, with gastric bypass for morbid obesity; with small intestine reconstruction to limit absorption	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1004 Bariatric Surgery	
43848	Revision, open, of gastric restrictive procedure for morbid obesity, other than adjustable gastric restrictive device (separate procedure)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1004 Bariatric Surgery	
43881	Implantation or replacement of gastric neurostimulator electrodes, antrum, open	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1235 Gastric Electrical Stimulation and Gastric Pacing	
43882	Revision or removal of gastric neurostimulator electrodes, antrum, open	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1235 Gastric Electrical Stimulation and Gastric Pacing	
43886	Gastric restrictive procedure, open; revision of subcutaneous port component only	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1004 Bariatric Surgery	
43887	Gastric restrictive procedure, open; removal of subcutaneous port component only	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1004 Bariatric Surgery	
43888	Gastric restrictive procedure, open; removal and replacement of subcutaneous port component only	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1004 Bariatric Surgery	
43999	Unlisted procedure, stomach	Prior authorization is required for not otherwise classified codes. Reference policies for additional information.	HHO-DE-MP-1139 Transesophageal Endoscopic Therapies for Gastroesophageal Reflux Disease	
44133	Donor enterectomy (including cold preservation), open; partial, from living donor	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1051 Small Bowel, Liver and Multivisceral Transplantation	
44135	Intestinal allotransplantation; from cadaver donor	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1051 Small Bowel, Liver and Multivisceral Transplantation	
44136	Intestinal allotransplantation; from living donor	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1051 Small Bowel, Liver and Multivisceral Transplantation	
44238	Laparoscopic procedure: Intestine (except rectum)	Prior authorization is required.		
44705	Preparation of fecal microbiota for instillation, including assessment of donor specimen	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1146 Fecal Microbiota Transplantation	
44799	Unlisted procedure, small intestine	Prior authorization is required. Reference policies for additional information. Prior authorization is required for not otherwise classified codes.	HHO-DE-MP-1146 Fecal Microbiota Transplantation and HHO-DE-MP-1051 Small Bowel, Liver and Multivisceral Transplantation	
44899	Unlisted procedure, Meckel's diverticulum and the mesentery	Prior authorization is required.		
44979	Unlisted laparoscopy procedure, appendix	Prior authorization is required.		
45399	Unlisted procedure, colon	Prior authorization is required.		
45499	Unlisted laparoscopy procedure, rectum	Prior authorization is required.		
45999	Unlisted procedure, rectum	Prior authorization is required.		
46999	Unlisted procedure, anus	Prior authorization is required.		
47135	Liver allotransplantation, orthotopic, partial or whole, from cadaver or living donor, any age	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1124 Liver Transplant and HHO-DE-MP-1051 Small Bowel, Liver and Multivisceral Transplantation	
47370	Laparoscopy, surgical, ablation of 1 or more liver tumor(s); radiofrequency	Prior authorization is required.		
47371	Laparoscopy, surgical, ablation of 1 or more liver tumor(s); cryosurgical	Prior authorization is required.		
47379	Laparoscopy procedure: Liver	Prior authorization is required.		
47380	Ablation, open, of 1 or more liver tumor(s); radiofrequency	Prior authorization is required.		
47381	Ablation, open, of 1 or more liver tumor(s); cryosurgical	Prior authorization is required.		
47382	Ablation, 1 or more liver tumor(s), percutaneous, radiofrequency	Prior authorization is required.		
47383	Ablation, 1 or more liver tumor(s), percutaneous, cryoablation	Prior authorization is required.		
47399	Unlisted procedure, liver	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1124 Liver Transplant and HHO-DE-MP-1051 Small Bowel, Liver and Multivisceral Transplantation	
47579	Unlisted laparoscopy procedure, biliary tract	Prior authorization is required.		
47999	Unlisted procedure, biliary tract	Prior authorization is required.		
48160	Pancreatectomy, total or subtotal, with autologous transplantation of pancreas or pancreatic islet cells	Prior authorization is required for transplants. Reference policies for additional information.	HHO-DE-MP-1021 Islet Cell Transplantation	
48550	Donor pancreatectomy (including cold preservation), with or without duodenal segment for transplantation	Prior authorization is required.		
48554	Transplantation of pancreatic allograft	Prior authorization is required.		
48556	Removal of transplanted pancreatic allograft	Prior authorization is required.		
48999	Unlisted procedure, pancreas	Prior authorization is required.		
49329	Laparoscopy procedure: Abdomen, peritoneum, omentum	Prior authorization is required.		
49659	Laparoscopic procedure: Hernioplasty, herniography, herniotomy	Prior authorization is required.		
49999	Procedure: Abdomen, peritoneum and omentum	Prior authorization is required.		

50250	Ablation, open, 1 or more renal mass lesion(s), cryosurgical, including intraoperative ultrasound guidance and monitoring, if performed	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1218 Radiofrequency Ablation of Miscellaneous Solid Tumors	
50320	Donor nephrectomy (including cold preservation); open, from living donor	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1017 Kidney Transplant	
50340	Recipient nephrectomy (separate procedure)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1017 Kidney Transplant	
50360	Renal allotransplantation, implantation of graft; without recipient nephrectomy	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1017 Kidney Transplant	
50365	Renal allotransplantation, implantation of graft; with recipient nephrectomy	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1017 Kidney Transplant	
50370	Removal of transplanted renal allograft	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1017 Kidney Transplant	
50380	Renal autotransplantation, reimplantation of kidney	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1017 Kidney Transplant	
50542	Laparoscopy, surgical; ablation of renal mass lesion(s), including intraoperative ultrasound guidance and monitoring, when performed	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1218 Radiofrequency Ablation of Miscellaneous Solid Tumors	
50547	Laparoscopy, surgical; donor nephrectomy (including cold preservation), from living donor	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1017 Kidney Transplant	
50549	Unlisted laparoscopy procedure, renal	Prior authorization is required.		
50592	Ablation, 1 or more renal tumor(s), percutaneous, unilateral, radiofrequency	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1218 Radiofrequency Ablation of Miscellaneous Solid Tumors	
50593	Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1218 Radiofrequency Ablation of Miscellaneous Solid Tumors	
50949	Unlisted laparoscopy procedure, ureter	Prior authorization is required.		
51999	Laparoscopy procedure: Bladder	Prior authorization is required.		
52441	Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; single implant	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1158 Treatment of Prostate	
52442	Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; each additional permanent adjustable transprostatic implant (List separately in addition to code for primary procedure)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1158 Treatment of Prostate	
52450	Transurethral incision of prostate	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1158 Treatment of Prostate	
52601	Transurethral electrosurgical resection of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation and internal urethrotomy are included)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1158 Treatment of Prostate	
52630	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)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1158 Treatment of Prostate	
52640	Transurethral resection; of postoperative bladder neck contracture	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1158 Treatment of Prostate	
52647	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)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1158 Treatment of Prostate	
52648	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)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1158 Treatment of Prostate	
52649	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)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1158 Treatment of Prostate	
53850	Transurethral destruction of prostate tissue; by microwave thermotherapy	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1158 Treatment of Prostate	
53852	Transurethral destruction of prostate tissue; by radiofrequency thermotherapy	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1158 Treatment of Prostate	
53854	Transurethral destruction of prostate tissue; by radiofrequency generated water vapor thermotherapy	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1158 Treatment of Prostate	
53855	Insertion of a temporary prostatic urethral stent, including urethral measurement	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1158 Treatment of Prostate	
53899	Unlisted procedure, urinary system	Prior authorization is required for not otherwise classified codes. Reference policies for additional information.	HHO-DE-MP-1117 Urinary Incontinence Therapy	
54699	Laporoscopic procedure: Testis	Prior authorization is required.		
55200	Vasotomy, cannulization with or without incision of vas, unilateral or bilateral (separate procedure)	Prior authorization and a signed consent of awareness form is required. Sterilization is not covered for members under age 21.		
55250	Vasectomy, unilateral or bilateral (separate procedure), including postoperative semen examination(s)	Prior authorization and a signed consent of awareness form is required. Sterilization is not covered for members under age 21.		
55300	Vasotomy for vasograms, seminal vesiculograms, or epididymograms, unilateral or bilateral	Prior authorization and a signed consent of awareness form is required. Sterilization is not covered for members under age 21.		
55559	Laparoscopy procedure: Spermatic cord	Prior authorization is required.		
55801	Prostatectomy, perineal, subtotal (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation and internal urethrotomy)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1158 Treatment of Prostate	
55810	Prostatectomy, perineal radical;	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1158 Treatment of Prostate	
55812	Prostatectomy, perineal radical; with lymph node biopsy(s) (limited pelvic lymphadenectomy)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1158 Treatment of Prostate	
55815	Prostatectomy, perineal radical; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric and obturator nodes	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1158 Treatment of Prostate	
55821	Prostatectomy (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation and internal urethrotomy); suprapubic, subtotal, 1 or 2 stages	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1158 Treatment of Prostate	
55831	Prostatectomy (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation and internal urethrotomy); retropubic, subtotal	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1158 Treatment of Prostate	
55840	Prostatectomy, retropubic radical, with or without nerve sparing;	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1158 Treatment of Prostate	

55842	Prostatectomy, retropubic radical, with or without nerve sparing; with lymph node biopsy(s) (limited pelvic lymphadenectomy)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1158 Treatment of Prostate	
55845	Prostatectomy, retropubic radical, with or without nerve sparing; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric and obturator nodes	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1158 Treatment of Prostate	
55873	Cryosurgical ablation of the prostate (includes ultrasonic guidance and monitoring)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1158 Treatment of Prostate	
55880	Ablation of malignant prostate tissue, transrectal, with high intensity-focused ultrasound (HIFU), including ultrasound guidance	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1158 Treatment of Prostate	
55899	Unlisted procedure, male genital system	Prior authorization is required for not otherwise classified codes.		
57156	Insertion of a vaginal radiation afterloading apparatus for clinical brachytherapy	Prior authorization is required for conditions other than cancer.		
57160	Fitting and insertion of pessary or other intravaginal support device	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1117 Urinary Incontinence Therapy	
57292	Construction of artificial vagina, with graft	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1216 Gender Affirmation Services	
57295	Revision (including removal) of prosthetic vaginal graft; vaginal approach	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1216 Gender Affirmation Services	
57296	Revision (including removal) of prosthetic vaginal graft; open approach	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1216 Gender Affirmation Services	
57335	Vaginoplasty for intersex state	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1216 Gender Affirmation Services	
57426	Revision (including removal) of prosthetic vaginal graft; laparoscopic approach	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1216 Gender Affirmation Services	
58150	Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s)	Prior authorization is required for Hysterectomies. Medical necessity criteria must be met. Reference policies for additional information.	HHO-DE-MP-1216 Gender Affirmation Services	
58152	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)	Prior authorization is required, medical necessity criteria must be met.		
58180	Supracervical abdominal hysterectomy (subtotal hysterectomy), with or without removal of tube(s), with or without removal of ovary(s)	Prior authorization is required for Hysterectomies. Medical necessity criteria must be met. Reference policies for additional information.	HHO-DE-MP-1216 Gender Affirmation Services	
58200	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)	Prior authorization is required, medical necessity criteria must be met.		
58210	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)	Prior authorization is required, medical necessity criteria must be met.		
58240	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	Prior authorization is required, medical necessity criteria must be met.		
58260	Vaginal hysterectomy, for uterus 250 g or less;	Prior authorization is required for Hysterectomies. Medical necessity criteria must be met. Reference policies for additional information.	HHO-DE-MP-1216 Gender Affirmation Services	
58262	Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)	Prior authorization is required for Hysterectomies. Medical necessity criteria must be met. Reference policies for additional information.	HHO-DE-MP-1216 Gender Affirmation Services	
58263	Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s), with repair of enterocele	Prior authorization is required, medical necessity criteria must be met.		
58267	Vaginal hysterectomy, for uterus 250 g or less; with colpo-urethrocystopexy (Marshall-Marchetti-Krantz type, Pereyra type) with or without endoscopic control	Prior authorization is required, medical necessity criteria must be met.		
58270	Vaginal hysterectomy, for uterus 250 g or less; with repair of enterocele	Prior authorization is required, medical necessity criteria must be met.		
58275	Vaginal hysterectomy, with total or partial vaginectomy	Prior authorization is required for Hysterectomies. Medical necessity criteria must be met. Reference policies for additional information.	HHO-DE-MP-1216 Gender Affirmation Services	
58280	Vaginal hysterectomy, with total or partial vaginectomy; with repair of enterocele	Prior authorization is required, medical necessity criteria must be met.		
58285	Vaginal hysterectomy, radical (Schauta type operation)	Prior authorization is required, medical necessity criteria must be met.		
58290	Vaginal hysterectomy, for uterus greater than 250 g	Prior authorization is required for Hysterectomies. Medical necessity criteria must be met. Reference policies for additional information.	HHO-DE-MP-1216 Gender Affirmation Services	
58291	Vaginal hysterectomy, for uterus greater than 250 g with removal of tube(s) and/or ovary(s)	Prior authorization is required for Hysterectomies. Medical necessity criteria must be met. Reference policies for additional information.	HHO-DE-MP-1216 Gender Affirmation Services	
58292	Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s), with repair of enterocele	Prior authorization is required, medical necessity criteria must be met.		
58294	Vaginal hysterectomy, for uterus greater than 250 g; with repair of enterocele	Prior authorization is required, medical necessity criteria must be met.		
58353	Endometrial ablation, thermal, without hysteroscopic guidance	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1156 Treatment of Abnormal Uterine Bleeding and Fibroids	
58356	Endometrial cryoablation with ultrasonic guidance, including endometrial curettage, when performed	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1156 Treatment of Abnormal Uterine Bleeding and Fibroids	
58541	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1216 Gender Affirmation Services	
58542	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1216 Gender Affirmation Services	
58543	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g;	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1216 Gender Affirmation Services	
58544	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1216 Gender Affirmation Services	
58550	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less;	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1216 Gender Affirmation Services	
58552	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)	Prior authorization is required for Hysterectomies. Medical necessity criteria must be met. Reference policies for additional information.	HHO-DE-MP-1216 Gender Affirmation Services	
58553	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g	Prior authorization is required for Hysterectomies. Medical necessity criteria must be met. Reference policies for additional information.	HHO-DE-MP-1216 Gender Affirmation Services	
58554	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)	Prior authorization is required for Hysterectomies. Medical necessity criteria must be met. Reference policies for additional information.	HHO-DE-MP-1216 Gender Affirmation Services	
58563	Hysteroscopy, surgical; with endometrial ablation (eg, endometrial resection, electrosurgical ablation, thermoablation)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1156 Treatment of Abnormal Uterine Bleeding and Fibroids	

58570	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1216 Gender Affirmation Services	
58571	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1216 Gender Affirmation Services	
58572	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1216 Gender Affirmation Services	
58573	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1216 Gender Affirmation Services	
58578	Laparoscopy procedure: Uterus	Prior authorization is required.		
58579	Laparoscopy procedure: Uterus	Prior authorization is required.		
58600	Ligation or transection of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral	Prior authorization and a signed consent of awareness form is required. Sterilization is not covered for members under age 21.		
58605	Ligation or transection of fallopian tube(s), abdominal or vaginal approach, postpartum, unilateral or bilateral, during same hospitalization (separate procedure)	Prior authorization and a signed consent of awareness form is required. Sterilization is not covered for members under age 21.		
58611	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)	Prior authorization and a signed consent of awareness form is required. Sterilization is not covered for members under age 21.		
58661	Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1216 Gender Affirmation Services	
58671	Laparoscopy, surgical; with occlusion of oviducts by device (eg, band, clip, or Falope ring)	Prior authorization and a signed consent of awareness form is required. Sterilization is not covered for members under age 21.		
58674	Laparoscopy, surgical, ablation of uterine fibroid(s) including intraoperative ultrasound guidance and monitoring, radiofrequency	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1156 Treatment of Abnormal Uterine Bleeding and Fibroids	
58679	Laparoscopy procedure: Ovary	Prior authorization is required.		
58720	Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1216 Gender Affirmation Services	
58940	Oophorectomy, partial or total, unilateral or bilateral;	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1216 Gender Affirmation Services	
58999	Unlisted procedure, female genital system (nonobstetrical)	Prior authorization is required. Reference policies for additional information. Prior authorization is required for not otherwise classified codes.	HHO-DE-MP-1215 Labiaplasty	
59001	Amniocentesis; therapeutic amniotic fluid reduction (includes ultrasound guidance)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1043 Treatment of Twin-Twin Transfusion Syndrome with Amnioreduction and/or Fetoscopic Laser Therapy	
59076	Fetal shunt placement, including ultrasound guidance	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1110 Fetal Surgery for Prenatally Diagnosed Malformations	
59840	Induced abortion, by dilation and curettage	Prior authorization is required. Elective abortions are not covered.		
59841	Induced abortion, by dilation and evacuation	Prior authorization is required. Elective abortions are not covered.		
59850	Induced abortion, by 1 or more intra-amniotic injections (amniocentesis-injections), including hospital admission and visits, delivery of fetus and secundines;	Prior authorization is required. Elective abortions are not covered.		
59851	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	Prior authorization is required. Elective abortions are not covered.		
59852	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)	Prior authorization is required. Elective abortions are not covered.		
59855	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;	Prior authorization is required. Elective abortions are not covered.		
59856	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	Prior authorization is required. Elective abortions are not covered.		
59857	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)	Prior authorization is required. Elective abortions are not covered.		
59866	Multifetal pregnancy reduction(s) (MPR)	Prior authorization is required. Elective abortions are not covered.		
59897	Unlisted fetal invasive procedure, including ultrasound guidance, when performed	Prior authorization is required. Reference policies for additional information. Prior authorization is required for not otherwise classified codes.	HHO-DE-MP-1110 Fetal Surgery for Prenatally Diagnosed Malformations	
59898	Unlisted laparoscopy procedure, maternity care and delivery	Prior authorization is required.		
59899	Unlisted procedure, maternity care and delivery	Prior authorization is required.		
60659	Unlisted laparoscopy procedure, endocrine system	Prior authorization is required.		
60699	Unlisted procedure, endocrine system	Prior authorization is required.		
61520	Craniectomy for excision of brain tumor, infratentorial or posterior fossa; cerebellopontine angle tumor	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1190 External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing	
61530	Craniectomy, bone flap craniotomy, transtemporal (mastoid) for excision of cerebellopontine angle tumor; combined with middle/posterior fossa craniotomy/craniectomy	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1190 External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing	
61598	Transpetrosal approach to posterior cranial fossa, clivus or foramen magnum, including ligation of superior petrosal sinus and/or sigmoid sinus	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1190 External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing	
61850	Twist drill or burr hole(s) for implantation of neurostimulator electrodes, cortical	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1009 Deep Brain Stimulation and HHO-DE-MP-1131 Responsive Neurostimulation for the Treatment of Refractory Partial Epilepsy	

61860	Craniectomy or craniotomy for implantation of neurostimulator electrodes, cerebral, cortical	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1009 Deep Brain Stimulation and HHO-DE-MP-1131 Responsive Neurostimulation for the Treatment of Refractory Partial Epilepsy	
61863	Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), without use of intraoperative microelectrode recording; first array	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1009 Deep Brain Stimulation and HHO-DE-MP-1131 Responsive Neurostimulation for the Treatment of Refractory Partial Epilepsy	
61864	Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), without use of intraoperative microelectrode recording; each additional array (List separately in addition to primary procedure)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1009 Deep Brain Stimulation and HHO-DE-MP-1131 Responsive Neurostimulation for the Treatment of Refractory Partial Epilepsy	
61867	Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), with use of intraoperative microelectrode recording; first array	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1009 Deep Brain Stimulation and HHO-DE-MP-1131 Responsive Neurostimulation for the Treatment of Refractory Partial Epilepsy	
61868	Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), with use of intraoperative microelectrode recording; each additional array (List separately in addition to primary procedure)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1009 Deep Brain Stimulation and HHO-DE-MP-1131 Responsive Neurostimulation for the Treatment of Refractory Partial Epilepsy	
61880	Revision or removal of intracranial neurostimulator electrodes	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1009 Deep Brain Stimulation and HHO-DE-MP-1131 Responsive Neurostimulation for the Treatment of Refractory Partial Epilepsy	
61885	Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1009 Deep Brain Stimulation and HHO-DE-MP-1131 Responsive Neurostimulation for the Treatment of Refractory Partial Epilepsy	
61886	Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to 2 or more electrode arrays	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1009 Deep Brain Stimulation and HHO-DE-MP-1131 Responsive Neurostimulation for the Treatment of Refractory Partial Epilepsy	
61888	Revision or removal of cranial neurostimulator pulse generator or receiver	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1009 Deep Brain Stimulation and HHO-DE-MP-1131 Responsive Neurostimulation for the Treatment of Refractory Partial Epilepsy	
61889	Insertion of skull-mounted cranial neurostimulator pulse generator or receiver, including craniectomy or craniotomy, when performed, with direct or inductive coupling, with connection to depth and/or cortical strip electrode array(s)			
62263	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	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
62264	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	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
62280	Injection/infusion of neurolytic substance (e.g., alcohol, phenol, iced saline solutions), with or without other therapeutic substance; subarachnoid	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
62281	Injection/infusion of neurolytic substance (e.g., alcohol, phenol, iced saline solutions), with or without other therapeutic substance; epidural, cervical or thoracic	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
62282	Injection/infusion of neurolytic substance (e.g., alcohol, phenol, iced saline solutions), with or without other therapeutic substance; epidural, lumbar, sacral (caudal)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
62287	Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, any method utilizing needle based technique to remove disc material under fluoroscopic imaging or other form of indirect visualization, with discography and/or epidural injection(s) at the treated level(s), when performed, single or multiple levels, lumbar	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
62292	Injection procedure for chemonucleolysis, including discography, intervertebral disc, single or multiple levels, lumbar	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
62320	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	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
62321	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)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
62322	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	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
62323	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)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.

62324	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	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
62325	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)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
62326	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	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
62327	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)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
62350	Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir/infusion pump; without laminectomy	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
62351	Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir/infusion pump; with laminectomy	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
62360	Implantation or replacement of device for intrathecal or epidural drug infusion; subcutaneous reservoir	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
62361	Implantation or replacement of device for intrathecal or epidural drug infusion; nonprogrammable pump	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
62362	Implantation or replacement of device for intrathecal or epidural drug infusion; programmable pump, including preparation of pump, with or without programming	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
62380	Endoscopic decompression of spinal cord, nerve root(s), including laminotomy, partial facetectomy, foraminotomy, discectomy and/or excision of herniated intervertebral disc, 1 interspace, lumbar	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
63001	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	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
63005	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
63012	Laminectomy with removal of abnormal facets and/or pars inter- articularis with decompression of cauda equina and nerve roots for spondylolisthesis, lumbar (Gill type procedure)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
63015	Laminectomy with exploration and/or decompression of spinal	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
63017	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	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
63020	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, cervical	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
63030	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
63035	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; each additional interspace, cervical or lumbar (List separately in addition to code for primary procedure)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
63040	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; cervical	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
63042	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; lumbar	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
63043	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; each additional cervical interspace (List separately in addition to code for primary procedure)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
63044	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; each additional lumbar interspace (List separately in addition to code for primary procedure)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
63045	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	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.

63047	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	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
63048	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; each additional vertebral segment, cervical, thoracic, or lumbar (List separately in addition to code for primary procedure)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
63050	Laminoplasty, cervical, with decompression of the spinal cord, 2 or more vertebral segments;	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
63051	Laminoplasty, cervical, with decompression of the spinal cord, 2 or more vertebral segments; with reconstruction of the posterior bony elements (including the application of bridging bone graft and non-segmental fixation devices [e.g., wire, suture, mini- plates], when performed)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
63052	Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [e.g., spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; single vertebral segment (List separately in addition to code for primary procedure)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
63053	Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [e.g., spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; each additional segment (List separately in addition to code for primary procedure)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
63056	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)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
63057	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)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
63075	Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, single interspace	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
63076	Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, each additional interspace (List separately in addition to code for primary procedure)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
63081	Vertebral corpectomy (vertebral body resection), partial or complete, anterior approach with decompression of spinal cord and/or nerve root(s); cervical, single segment	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
63082	Vertebral corpectomy (vertebral body resection), partial or complete, anterior approach with decompression of spinal cord and/or nerve root(s); cervical, each additional segment (List separately in addition to code for primary procedure)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
63650	Percutaneous implantation of neurostimulator electrode array, epidural	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
63655	Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, requiring pocket creation and connection between electrode array and pulse generator or receiver	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
64400	Injection(s), anesthetic agent(s) and/or steroid; trigeminal nerve, each branch (ie, ophthalmic, maxillary, mandibular)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1136 Temporomandibular Joint Dysfunction	
64408	Injection(s), anesthetic agent(s) and/or steroid; vagus nerve	Prior authorization is required.		
64451	Injection(s), anesthetic agent(s) and/or steroid; nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
64479	Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), cervical or thoracic, single level	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
64480	Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), cervical or thoracic, each additional level (List separately in addition to code for primary procedure)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
64483	Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, single level	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
64484	Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, each additional level (List separately in addition to code for primary procedure)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
64490	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; single level	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
64491	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; second level (List separately in addition to code for primary procedure)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
64492	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; third and any additional level(s) (List separately in addition to code for primary procedure)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
64493	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.

64494	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; second level (List separately in addition to code for primary procedure)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
64495	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; third and any additional level(s) (List separately in addition to code for primary procedure)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
64510	Injection, anesthetic agent; stellate ganglion (cervical sympathetic)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
64520	Injection, anesthetic agent; lumbar or thoracic (paravertebral sympathetic)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
64553	Percutaneous implantation of neurostimulator electrode array; cranial nerve	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1238 Electrical Nerve Stimulation	
64566	Posterior tibial neurostimulation, percutaneous needle electrode, single treatment, includes programming	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1237 Posterior Tibial Nerve Stimulation	
64568	Open implantation of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator	Prior authorization is required for Vagus Nerve Stimulation. Reference policies for additional information.	HHO-DE-MP-1064 Diagnosis and Treatment of Obstructive Sleep Apnea in Adults and HHO-DE-MP-1065 Diagnosis and Treatment of Obstructive Sleep Apnea in Pediatric Individuals	
64569	Revision or replacement of cranial nerve (eg, vagus nerve) neurostimulator electrode array, including connection to existing pulse generator	Prior authorization is required for Vagus Nerve Stimulation. Reference policies for additional information.	HHO-DE-MP-1064 Diagnosis and Treatment of Obstructive Sleep Apnea in Adults and HHO-DE-MP-1065 Diagnosis and Treatment of Obstructive Sleep Apnea in Pediatric Individuals	
64570	Removal of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator	Prior authorization is required for Vagus Nerve Stimulation. Reference policies for additional information.	HHO-DE-MP-1064 Diagnosis and Treatment of Obstructive Sleep Apnea in Adults	
64575	Open implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1238 Electrical Nerve Stimulation	
64580	Open implantation of neurostimulator electrode array; neuromuscular	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1238 Electrical Nerve Stimulation	
64582	Open implantation of hypoglossal nerve neurostimulator array, pulse generator and distal respiratory sensor electrode or electrode array	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1064 Diagnosis and Treatment of Obstructive Sleep Apnea in Adults and HHO-DE-MP-1065 Diagnosis and Treatment of Obstructive Sleep Apnea in Pediatric Individuals	
64585	Revision or removal of peripheral neurostimulator electrode array	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1238 Electrical Nerve Stimulation	
64590	Insertion or replacement of peripheral, sacral, or gastric neurostimulator pulse generator or receiver, requiring pocket creation and connection between electrode array and pulse generator or receiver	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1235 Gastric Electrical Stimulation and Gastric Pacing	
64595	Revision or removal of peripheral, sacral, or gastric neurostimulator pulse generator or receiver, with detachable connection to electrode array	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1235 Gastric Electrical Stimulation and Gastric Pacing	
64625	Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
64633	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
64634	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional facet joint (List separately in addition to code for primary procedure)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
64635	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
64636	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional facet joint (List separately in addition to code for primary procedure)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
64650	Chemodenervation of eccrine glands; both axillae	Prior authorization is required. Reference policies for additional information. DE-MP-1137 Hyperhidrosis		
64653	Chemodenervation of eccrine glands; other area(s) (eg, scalp, face, neck), per day	Prior authorization is required. Reference policies for additional information. DE-MP-1137 Hyperhidrosis		
64670	Removal of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1064 Diagnosis and Treatment of Obstructive Sleep Apnea in Adults and HHO-DE-MP-1065 Diagnosis and Treatment of Obstructive Sleep Apnea in Pediatric Individuals	
64721	Neuroplasty and/or transposition; median nerve at carpal tunnel	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1038 Carpal Tunnel	
64755	Transection or avulsion of; vagus nerves limited to proximal stomach (selective proximal vagotomy, proximal gastric vagotomy, parietal cell vagotomy, supra- or highly selective vagotomy)	Prior authorization is required.		
64760	Transection or avulsion of; vagus nerve (vagotomy), abdominal	Prior authorization is required.		
64999	Unlisted Procedure: Nervous system	Prior authorization is required.		
65710	Keratoplasty (corneal transplant); anterior lamellar	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1221 Corneal Transplantation	
65730	Keratoplasty (corneal transplant); penetrating (except in aphakia or pseudophakia)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1221 Corneal Transplantation	
65750	Keratoplasty (corneal transplant); penetrating (in aphakia)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1221 Corneal Transplantation	
65755	Keratoplasty (corneal transplant); penetrating (in pseudophakia)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1221 Corneal Transplantation	
65756	Keratoplasty (corneal transplant); endothelial	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1221 Corneal Transplantation	
65757	Backbench preparation of corneal endothelial allograft prior to transplantation (List separately in addition to code for primary procedure)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1221 Corneal Transplantation	

65760	Keratomileusis	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1099 Corneal Surgery to Correct Refractive Errors, Phototherapeutic Keratectomy and Corneal Collagen Cross-Linking Surgery	
65765	Keratophakia	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1099 Corneal Surgery to Correct Refractive Errors, Phototherapeutic Keratectomy and Corneal Collagen Cross-Linking Surgery	
65767	Epikeratoplasty	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1099 Corneal Surgery to Correct Refractive Errors, Phototherapeutic Keratectomy and Corneal Collagen Cross-Linking Surgery	
65770	Keratoprosthesis	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1221 Corneal Transplantation	
65771	Radial keratotomy	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1099 Corneal Surgery to Correct Refractive Errors, Phototherapeutic Keratectomy and Corneal Collagen Cross-Linking Surgery	
65780	Ocular surface reconstruction; amniotic membrane transplantation, multiple layers	Prior authorization is required.		
66174	Transluminal dilation of aqueous outflow canal; without retention of device or stent	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1024 Aqueous Shunts and Stents for Glaucoma	
66175	Transluminal dilation of aqueous outflow canal; with retention of device or stent	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1024 Aqueous Shunts and Stents for Glaucoma	
66183	Insertion of anterior segment aqueous drainage device, without extraocular reservoir, external approach	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1024 Aqueous Shunts and Stents for Glaucoma	
66989	Extrascapular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (e.g., iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage; with insertion of intraocular (e.g., trabecular meshwork, supraciliary, suprachoroidal) anterior segment aqueous drainage	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1024 Aqueous Shunts and Stents for Glaucoma	
66991	Extrascapular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification); with insertion of intraocular (e.g., trabecular meshwork, supraciliary, suprachoroidal) anterior segment aqueous drainage device, without extraocular reservoir, internal approach, one or more	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1024 Aqueous Shunts and Stents for Glaucoma	
66999	Unlisted procedure, anterior segment of eye	Prior authorization is required.		
67299	Unlisted procedure, posterior segment	Prior authorization is required.		
67399	Unlisted procedure, extraocular muscle	Prior authorization is required.		
67599	Unlisted procedure, orbit	Prior authorization is required.		
67999	Unlisted procedure: Eyelid	Prior authorization is required.		
68399	Procedure: Conjunctiva (eye)	Prior authorization is required.		
69399	Procedure: External ear	Prior authorization is required.		
69676	Tympanic neurectomy	Prior authorization is required. Reference policies for additional information. DE-MP-1137 Hyperhidrosis		
69714	Implantation, osseointegrated implant, skull; with percutaneous attachment to external speech processor	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1190 External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing	
69799	Unlisted procedure, middle ear	Prior authorization is required.		
69930	Cochlear device implantation, with or without mastoidectomy	Prior authorization is required. Reference policies for additional information and for medical necessity criteria.	HHO-DE-MP-1145 Cochlear Implants	
69949	Unlisted procedure, inner ear	Prior authorization is required.		
69979	Unlisted procedure, temporal bone, middle fossa approach	Prior authorization is required.		
70250	X-ray of skull, fewer than 4 views	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1136 Temporomandibular Joint Dysfunction	
70260	Radiologic examination, skull; complete, minimum of 4 views	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1136 Temporomandibular Joint Dysfunction	
70332	Temporomandibular joint arthrography, radiological supervision and interpretation	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1136 Temporomandibular Joint Dysfunction	
70336	Magnetic resonance (eg, proton) imaging, temporomandibular joint(s)	Prior authorization is managed by EviCore. Reference policies for additional information.	HHO-DE-MP-1136 Temporomandibular Joint Dysfunction	Prior authorization is managed by EviCore.
70350	Cephalogram, orthodontic	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1136 Temporomandibular Joint Dysfunction	
70355	Orthopantogram (eg, panoramic x-ray)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1136 Temporomandibular Joint Dysfunction	
70450	CT Head Without Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
70460	CT Head With Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
70470	CT Head Without & With Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
70480	CT Orbit Without Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
70481	CT Orbit With Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
70482	CT Orbit Without & With Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
70486	Computed tomography, maxillofacial area; without contrast material	Prior authorization is managed by EviCore. Reference policies for additional information.	HHO-DE-MP-1136 Temporomandibular Joint Dysfunction	Prior authorization is managed by EviCore.

70487	Computed tomography, maxillofacial area; with contrast material(s)	Prior authorization is managed by EviCore. Reference policies for additional information.	HHO-DE-MP-1136 Temporomandibular Joint Dysfunction	Prior authorization is managed by EviCore.
70488	Computed tomography, maxillofacial area; without contrast material, followed by contrast material(s) and further sections	Prior authorization is managed by EviCore. Reference policies for additional information.	HHO-DE-MP-1136 Temporomandibular Joint Dysfunction	Prior authorization is managed by EviCore.
70490	C T Soft Tissue Neck Without Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
70491	C T Soft Tissue Neck With Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
70492	C T Soft Tissue Neck Without & With Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
70496	C T Angiography Head	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
70498	C T Angiography Neck	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
70540	M R I Orbit, Face and/or Neck Without Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
70542	M R I Face, Orbit and/or Neck With Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
70543	M R I Face, Orbit and/or Neck With & Without Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
70544	M R A Head Without Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
70545	M R A Head With Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
70546	M R A Head With & Without Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
70547	M R A Neck Without Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
70548	M R A Neck With Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
70549	M R A Neck With & Without Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
70551	M R I Head Without Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
70552	M R I Head With Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
70553	M R I Head With & Without Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
70554	MRI Brain, functional MRI	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
70555	MRI Brain, functional MRI, requiring physician	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
71250	C T Thorax Without Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
71260	C T Thorax With Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
71270	C T Thorax Without & With Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
71271	Computed tomography, thorax, low dose for lung cancer screening, without contrast material(s)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
71275	C T Angiography Chest Without Contrast Material, Followed by Contrast Material and Further Sections,Including Image Postprocessing	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
71550	M R I Chest Without Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
71551	M R I Chest With Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
71552	M R I Chest With & Without Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
71555	M R A Chest (Excluding Myocardium) With Or Without Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
72020	Radiologic examination, spine, single view, specify level	Prior authorization is required for members under age 13 when performed by a Chiropractor. Reference policies for additional information.	HHO-DE-RP-1120 Chiropractic Benefits and Services	
72040	Radiologic examination, spine, cervical; 2 or 3 views	Prior authorization is required for members under age 13 when performed by a Chiropractor. Reference policies for additional information.	HHO-DE-RP-1120 Chiropractic Benefits and Services	
72050	Radiologic examination, spine, cervical; 4 or 5 views	Prior authorization is required for members under age 13 when performed by a Chiropractor. Reference policies for additional information.	HHO-DE-RP-1120 Chiropractic Benefits and Services	
72052	Radiologic examination, spine, cervical; 6 or more views	Prior authorization is required for members under age 13 when performed by a Chiropractor. Reference policies for additional information.	HHO-DE-RP-1120 Chiropractic Benefits and Services	
72070	Radiologic examination, spine; thoracic, 2 views	Prior authorization is required for members under age 13 when performed by a Chiropractor. Reference policies for additional information.	HHO-DE-RP-1120 Chiropractic Benefits and Services	

72072	Radiologic examination, spine; thoracic, 3 views	Prior authorization is required for members under age 13 when performed by a Chiropractor. Reference policies for additional information.	HHO-DE-RP-1120 Chiropractic Benefits and Services	
72074	Radiologic examination, spine; thoracic, minimum of 4 views	Prior authorization is required for members under age 13 when performed by a Chiropractor. Reference policies for additional information.	HHO-DE-RP-1120 Chiropractic Benefits and Services	
72080	Radiologic examination, spine; thoracolumbar junction, minimum of 2 views	Prior authorization is required for members under age 13 when performed by a Chiropractor. Reference policies for additional information.	HHO-DE-RP-1120 Chiropractic Benefits and Services	
72081	Radiologic Examination, spine, entire thoracic and lumbar, including skull, cervical and sacral spine if performed (e.g. scoliosis evaluation); 1 view	Prior authorization is required for members under age 13 when performed by a Chiropractor. Reference policies for additional information.	HHO-DE-RP-1120 Chiropractic Benefits and Services	
72082	Radiologic Examination, spine, entire thoracic and lumbar, including skull, cervical and sacral spine if performed (e.g. scoliosis evaluation); 2 or 3 views	Prior authorization is required for members under age 13 when performed by a Chiropractor. Reference policies for additional information.	HHO-DE-RP-1120 Chiropractic Benefits and Services	
72083	Radiologic Examination, spine, entire thoracic and lumbar, including skull, cervical and sacral spine if performed (e.g. scoliosis evaluation); 4 or 5 views	Prior authorization is required for members under age 13 when performed by a Chiropractor. Reference policies for additional information.	HHO-DE-RP-1120 Chiropractic Benefits and Services	
72084	Radiologic Examination, spine, entire thoracic and lumbar, including skull, cervical and sacral spine if performed (e.g. scoliosis evaluation); minimum of 6 views	Prior authorization is required for members under age 13 when performed by a Chiropractor. Reference policies for additional information.	HHO-DE-RP-1120 Chiropractic Benefits and Services	
72100	Radiologic examination, spine, lumbosacral; 2 or 3 views	Prior authorization is required for members under age 13 when performed by a Chiropractor. Reference policies for additional information.	HHO-DE-RP-1120 Chiropractic Benefits and Services	
72110	Radiologic examination, spine, lumbosacral; minimum of 4 views	Prior authorization is required for members under age 13 when performed by a Chiropractor. Reference policies for additional information.	HHO-DE-RP-1120 Chiropractic Benefits and Services	
72114	Radiologic examination, spine, lumbosacral; complete, including bending views, minimum of 6 views	Prior authorization is required for members under age 13 when performed by a Chiropractor. Reference policies for additional information.	HHO-DE-RP-1120 Chiropractic Benefits and Services	
72120	Radiologic examination, spine, lumbosacral; bending views only, 2 or 3 views	Prior authorization is required for members under age 13 when performed by a Chiropractor. Reference policies for additional information.	HHO-DE-RP-1120 Chiropractic Benefits and Services	
72125	C T Cervical Spine Without Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
72126	C T Cervical Spine With Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
72127	C T Cervical Spine Without & With Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
72128	C T Thoracic Spine Without Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
72129	C T Thoracic Spine With Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
72130	C T Thoracic Spine Without & With Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
72131	C T Lumbar Spine Without Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
72132	C T Lumbar Spine With Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
72133	C T Lumbar Spine Without & With Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
72141	M R I Cervical Spine Without Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
72142	M R I Cervical Spine With Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
72146	M R I Thoracic Spine Without Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
72147	M R I Thoracic Spine With Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
72148	M R I Lumbar Spine Without Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
72149	M R I Lumbar Spine With Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
72156	M R I Cervical Spine With & Without Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
72157	M R I Thoracic Spine With & Without Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
72158	M R I Lumbar Spine With & Without Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
72159	M R A Spinal Canal With Or Without Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
72170	Radiologic examination, pelvis; 1 or 2 views	Prior authorization is required for members under age 13 when performed by a Chiropractor. Reference policies for additional information.	HHO-DE-RP-1120 Chiropractic Benefits and Services	
72190	Radiologic examination, pelvis; complete, minimum of 3 views	Prior authorization is required for members under age 13 when performed by a Chiropractor. Reference policies for additional information.	HHO-DE-RP-1120 Chiropractic Benefits and Services	
72191	C T Angiography Pelvis	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
72192	C T Pelvis Without Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
72193	C T Pelvis With Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.

72194	C T Pelvis Without & With Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
72195	M R I Pelvis Without Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
72196	M R I Pelvis With Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
72197	M R I Pelvis With & Without Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
72198	M R A Pelvis With Or Without Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
72200	Radiologic Examination, sacroiliac joints; less than 3 views	Prior authorization is required for members under age 13 when performed by a Chiropractor. Reference policies for additional information.	HHO-DE-RP-1120 Chiropractic Benefits and Services	
72202	Radiologic examination, sacroiliac joints; 3 or more views	Prior authorization is required for members under age 13 when performed by a Chiropractor. Reference policies for additional information.	HHO-DE-RP-1120 Chiropractic Benefits and Services	
72220	Radiologic examination, sacrum and coccyx, minimum of 2 views	Prior authorization is required for members under age 13 when performed by a Chiropractor. Reference policies for additional information.	HHO-DE-RP-1120 Chiropractic Benefits and Services	
73200	C T Upper Extremity Without Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
73201	C T Upper Extremity With Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
73202	C T Upper Extremity Without & With Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
73206	C T Angiography Upper Extremity	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
73218	M R I Upper Extremity Without Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
73219	M R I Upper Extremity With Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
73220	M R I Upper Extremity With & Without Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
73221	M R I Upper Extremity Joint Without Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
73222	M R I Upper Extremity Joint With Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
73223	M R I Upper Extremity Joint With & Without Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
73225	M R A Upper Extremity With Or Without Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
73700	C T Lower Extremity Without Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
73701	C T Lower Extremity With Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
73702	C T Lower Extremity Without & With Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
73706	C T Angiography Lower Extremity	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
73718	M R I Lower Extremity Without Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
73719	M R I Lower Extremity With Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
73720	M R I Lower Extremity With & Without Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
73721	M R I Lower Extremity Joint Without Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
73722	M R I Lower Extremity Joint With Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
73723	M R I Lower Extremity Joint With & Without Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
73725	M R A Lower Extremity With Or Without Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
74150	C T Abdomen Without Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
74160	C T Abdomen With Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
74170	C T Abdomen Without & With Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
74174	CT angiography, abdomen and pelvis, with contrast material(s), including noncontrast images, if performed and image postprocessing	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
74175	C T Angiography Abdomen	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.

74176	CT Abdomen And Pelvis Without Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
74177	CT Abdomen And Pelvis With Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
74178	Computed Tomography, Abdomen And Pelvis; Without Contrast Material In One Or Both Body Regions, Followed By Contrast Material(S) And Further Sections In One Or Both Body Regions	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
74181	M R I Abdomen Without Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
74182	M R I Abdomen With Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
74183	M R I Abdomen With & Without Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
74185	M R A Abdomen With Or Without Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
74261	Computed tomographic (CT) colonography, diagnostic, including image postprocessing; without contrast material	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
74262	Computed tomographic (CT) colonography, diagnostic, including image postprocessing; with contrast material(s) including non-contrast images, if performed	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
74263	Computed tomographic (CT) colonography, screening, including image postprocessing	Prior authorization is managed by EviCore. For members under age 45. Reference policies for additional information.	HHO-DE-MP-1007 Colorectal Cancer Screening	Prior authorization is managed by EviCore.
74280	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	Prior authorization is required for members under the age of 45. Reference policies for additional information.	HHO-DE-MP-1007 Colorectal Cancer Screening	
74712	Magnetic resonance (eg, proton) imaging, fetal, including placental and maternal pelvic imaging when performed; single or first gestation	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
74713	Magnetic resonance (eg, proton) imaging, fetal, including placental and maternal pelvic imaging when performed; each additional gestation (List separately in addition to code for primary procedure)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
75557	Cardiac magnetic resonance imaging for morphology and function without contrast material	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
75559	Cardiac magnetic resonance imaging for morphology and function without contrast material; with stress imaging	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
75561	Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
75563	Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences; with stress imaging	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
75565	Cardiac magnetic resonance imaging for velocity flow mapping (list separately in addition to code for primary procedure)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
75571	Computed tomography, heart, without contrast material, with quantitative evaluation of coronary calcium	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
75572	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)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
75573	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)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
75574	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)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
75580	Noninvasive estimate of coronary fractional flow reserve (FFR) derived from augmentative software analysis of the data set from a coronary computed tomography angiography, with interpretation and report by a physician or other qualified health care professional	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
75635	C T Angiography Abdominal Aorta	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
75894	Transcatheter therapy, embolization, any method, radiological supervision and interpretation	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1156 Treatment of Abnormal Uterine Bleeding and Fibroids	
75956	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	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1157 Endovascular/Endoluminal Stent Grafts	
75957	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	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1157 Endovascular/Endoluminal Stent Grafts	

75958	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	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1157 Endovascular/Endoluminal Stent Grafts	
75959	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	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1157 Endovascular/Endoluminal Stent Grafts	
76376	3D Rendering W/O Postprocessing	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
76377	3D Rendering W Postprocessing	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
76380	C T Limited Or Localized Follow-Up Study	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
76390	M R I Spectroscopy	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
76391	Magnetic resonance (eg, vibration) elastography	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
76496	Unlisted fluoroscopic procedure (eg, diagnostic, interventional)	Prior authorization is required.		
76497	Unlisted computed tomography procedure (eg, diagnostic, interventional)	Prior authorization is required.		
76498	Unlisted magnetic resonance procedure (eg, diagnostic, interventional)	Prior authorization is required.		
76499	Unlisted diagnostic radiographic procedure	Prior authorization is required for not otherwise classified codes.		
76536	Ultrasound, soft tissues of head and neck (eg, thyroid, parathyroid, parotid), real time with image documentation	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1136 Temporomandibular Joint Dysfunction	
76706	Ultrasound, abdominal aorta, real time with image documentation, screening study for abdominal aortic aneurysm (AAA)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1157 Endovascular/Endoluminal Stent Grafts	
76882	Ultrasound, extremity, nonvascular, real-time with image documentation; limited, anatomic specific	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1253 Ultrasound Guidance for Joint, Tendon, Tendon Sheath and Trigger Point Injections	
76942	Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1100 Surgical Treatment of Varicose Veins and HHO-DE-MP-1253 Ultrasound Guidance for Joint, Tendon, Tendon Sheath and Trigger Point Injections	
76977	Ultrasound bone density measurement and interpretation, peripheral site(s), any method	Prior authorization is required.		
76998	Ultrasonic guidance, intraoperative	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1100 Surgical Treatment of Varicose Veins	
76999	Unlisted ultrasound procedure (eg, diagnostic, interventional)	Prior authorization is required for not otherwise classified codes.		
77021	M R I Guidance For Needle Placement	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
77022	Magnetic resonance imaging guidance for and monitoring of, parenchymal tissue ablation	Prior authorization is required and managed by EviCore. Reference policies for additional information.	HHO-DE-MP-1156 Treatment of Abnormal Uterine Bleeding and Fibroids	Prior authorization is managed by EviCore.
77046	Magnetic resonance imaging, breast, without contrast material; unilateral	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
77047	Magnetic resonance imaging, breast, without contrast material; bilateral	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
77048	Magnetic resonance imaging, breast, without and with contrast material(s), including computer-aided detection (CAD real-time lesion detection, characterization and pharmacokinetic analysis), when performed; unilateral	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
77049	Magnetic resonance imaging, breast, without and with contrast material(s), including computer-aided detection (CAD real-time lesion detection, characterization and pharmacokinetic analysis), when performed; bilateral	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
77078	Computed tomography, bone mineral density study, 1 or more sites, axial skeleton (eg, hips, pelvis, spine)	Prior authorization is required and managed by EviCore. Reference policies for additional information.	HHO-DE-MP-1105 Bone Mineral Density Studies	Prior authorization is managed by EviCore.
77084	Magnetic resonance (eg, proton) imaging, bone marrow blood supply	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
77299	Unlisted procedure, therapeutic radiology clinical treatment planning	Prior authorization is required.		
77371	Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; multi-source Cobalt 60 based	Prior authorization is required for conditions other than cancer.		
77372	Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; linear accelerator based	Prior authorization is required for conditions other than cancer.		
77373	Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions	Prior authorization is required for conditions other than cancer.		
77385	Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; simple	Prior authorization is required.		
77386	Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; complex	Prior authorization is required.		
77387	Guidance for localization of target volume for delivery of radiation treatment, includes intrafraction tracking, when performed	Prior authorization is required for conditions other than cancer.		
77399	Unlisted procedure, medical radiation physics, dosimetry and treatment devices and special services	Prior authorization is required for conditions other than cancer.		
77401	Radiation treatment delivery, superficial and/or ortho voltage, per day	Prior authorization is required for conditions other than cancer.		
77402	Radiation treatment delivery, => 1 MeV; simple	Prior authorization is required for conditions other than cancer.		
77407	Radiation treatment delivery, => 1 MeV; intermediate	Prior authorization is required for conditions other than cancer.		
77412	Radiation treatment delivery, => 1 MeV; complex	Prior authorization is required for conditions other than cancer.		

77417	Therapeutic radiology port image(s)	Prior authorization is required for conditions other than cancer.		
77423	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)	Prior authorization is required for conditions other than cancer.		
77424	Intraoperative radiation treatment delivery, x-ray, single treatment session	Prior authorization is required for conditions other than cancer.		
77425	Intraoperative radiation treatment delivery, electrons, single treatment session	Prior authorization is required for conditions other than cancer.		
77427	Radiation treatment management, 5 treatments	Prior authorization is required for conditions other than cancer.		
77431	Radiation therapy management with complete course of therapy consisting of 1 or 2 fractions only	Prior authorization is required for conditions other than cancer.		
77432	Stereotactic radiation treatment management of cranial lesion(s) (complete course of treatment consisting of 1 session)	Prior authorization is required for conditions other than cancer.		
77435	Stereotactic body radiation therapy, treatment management, per treatment course, to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions	Prior authorization is required for conditions other than cancer.		
77469	Intraoperative radiation treatment management	Prior authorization is required for conditions other than cancer.		
77470	Special treatment procedure (eg, total body irradiation, hemibody radiation, per oral or endocavitary irradiation)	Prior authorization is required for conditions other than cancer.		
77499	Unlisted procedure, therapeutic radiology treatment management	Prior authorization is required.		
77520	Proton treatment delivery; simple, without compensation	Prior authorization is required.		
77522	Proton treatment delivery; simple, with compensation	Prior authorization is required.		
77523	Proton treatment delivery; intermediate	Prior authorization is required.		
77525	Proton treatment delivery; complex	Prior authorization is required.		
77761	Intracavitary radiation source application; simple	Prior authorization is required for conditions other than cancer.		
77762	Intracavitary radiation source application; intermediate	Prior authorization is required for conditions other than cancer.		
77763	Intracavitary radiation source application; complex	Prior authorization is required for conditions other than cancer.		
77778	Interstitial radiation source application, complex, includes supervision, handling, loading of radiation source, when performed	Prior authorization is required for conditions other than cancer.		
77799	Unlisted procedure, clinical brachytherapy	Prior authorization is required.		
78012	Thyroid uptake, single or multiple quantitative measurement(s) (including stimulation, suppression, or discharge, when performed)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78013	Thyroid imaging (including vascular flow, when performed)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78014	Thyroid imaging (including vascular flow, when performed); with single or multiple uptake(s) quantitative measurement(s) (including stimulation, suppression, or discharge, when performed)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78015	Thyroid Met Imaging	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78016	Thyroid Met Imaging With Additional Studies	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78018	Thyroid Scan Whole Body	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78020	Thyroid Carcinoma Metastases Uptake	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78070	Parathyroid planar imaging (including subtraction, when performed)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78071	Parathyroid planar imaging (including subtraction, when performed); with tomographic (SPECT)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78072	Parathyroid planar imaging (including subtraction, when performed); with tomographic (SPECT) and concurrently acquired computed tomography (CT) for anatomical localization	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78075	Adrenal Nuclear Imaging	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78099	Unlisted endocrine procedure, diagnostic nuclear medicine	Prior authorization is required.		
78102	Bone Marrow Imaging, Limited	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78103	Bone Marrow Imaging, Multiple	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78104	Bone Marrow Imaging, Whole Body	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78140	Labeled Red Cell Sequestration	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78185	Spleen Imaging With & Without Vascular Flow	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78195	Lymph System Imaging	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78199	Unlisted hematopoietic, reticuloendothelial and lymphatic procedure, diagnostic nuclear medicine	Prior authorization is required.		
78201	Liver Imaging	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78202	Liver Imaging With Flow	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78215	Liver & Spleen Imaging	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.

78216	Liver & Spleen Imaging With Flow	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78226	Hepatobiliary system imaging, including gallbladder when present;	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78227	Hepatobiliary system imaging, including gallbladder when present; with pharmacologic intervention, including quantitative measurement(s) when performed	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78230	Salivary Gland Imaging	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78231	Serial Salivary Gland	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78232	Salivary Gland Function Exam	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78258	Esophogus Motility Study	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78261	Gastric Mucosa Imaging	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78262	Gastroesophageal Reflux Exam	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78264	Gastric Emptying Study	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78265	Gastric emptying imaging study (eg, solid, liquid, or both); with small bowel transit	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78266	Gastric emptying imaging study (eg, solid, liquid, or both); with small bowel and colon transit, multiple days	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78278	GI Bleeder Scan	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78290	Meckels Diverticulum Imaging	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78291	Leveen Shunt Patency Exam	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78299	Unlisted gastrointestinal procedure, diagnostic nuclear medicine	Prior authorization is required.		
78300	Bone and/or joint imaging; limited area	Prior authorization is required and managed by EviCore. Reference policies for additional information.	HHO-DE-MP-1136 Temporomandibular Joint Dysfunction	Prior authorization is managed by EviCore.
78305	Bone and/or joint imaging; multiple areas	Prior authorization is required and managed by EviCore. Reference policies for additional information.	HHO-DE-MP-1136 Temporomandibular Joint Dysfunction	Prior authorization is managed by EviCore.
78306	Bone Scan Whole Body	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78315	Bone Scan 3 Phase Study	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78399	Unlisted musculoskeletal procedure, diagnostic nuclear medicine	Prior authorization is required.		
78414	Non-Imaging Heart Function	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78428	Cardiac Shunt Imaging	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78429	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	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78430	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	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78431	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	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78432	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);	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78433	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	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78434	Absolute quantitation of myocardial blood flow (AQMBF), positron emission tomography (PET), rest and pharmacologic stress (List separately in addition to code for primary procedure)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78445	Radionuclide Venogram Non-Cardiac	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78451	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)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.

78452	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	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78453	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)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78454	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	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78456	Acute Venous Thrombosis Imaging	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78457	Venous Thrombosis Imaging Unilateral	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78458	Venous Thrombosis Images, Bilateral	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78459	Myocardial imaging, positron emission tomography (PET), metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), single study	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78466	Myocardial Infarction Scan	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78468	Heart Infarct Image Ejection Fraction	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78469	Heart Infarct Image 3D SPECT	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78472	Cardiac Bloodpool Img, Single	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78473	Cardiac Bloodpool Img, Multi	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78481	Heart First Pass Single	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78483	Cardiac Blood Pool Imaging -- Multiple	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78491	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)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78492	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)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78494	Cardiac Blood Pool Imaging , SPECT	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78496	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)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78499	Unlisted Cardiovascular Procedure	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78579	Pulmonary ventilation imaging (eg, aerosol or gas)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78580	Pulmonary perfusion imaging (eg, particulate)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78582	Pulmonary ventilation (eg, aerosol or gas) and perfusion imaging	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78597	Quantitative differential pulmonary perfusion, including imaging when performed	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78598	Quantitative differential pulmonary perfusion and ventilation (eg, aerosol or gas), including imaging when performed	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78599	Unlisted respiratory procedure, diagnostic nuclear medicine	Prior authorization is required.		
78600	Brain Imaging Limited Static	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78601	Brain Limited Imaging And Flow	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78605	Brain Imaging Complete	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78606	Brain Imaging Complete With Flow	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78610	Brain Flow Imaging Only	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78630	Cisternogram (Cerebrospinal Fluid Flow)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.

78635	Cerebrospinal Ventriculography	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78645	CSF Shunt Evaluation	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78650	C S F Leakage Detection And Localization	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78660	Radiopharmaceutical Dacryocystography	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78699	Unlisted Nuclear Medicine Procedures on the Nervous System	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78700	Kidney Imaging Morphology	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78701	Kidney Imaging With Vascular Flow	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78707	Kidney Imaging With Vascular Flow & Function Single Study Without Pharmacological Intervention	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78708	Kidney Imaging Single Study With Pharmacological Intervention	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78709	Kidney Imaging - Multiple Studies Without & With Pharmacological Intervention	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78725	Kidney Function Study - Non-Imaging Radioisotopic	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78730	Urinary Bladder Residual Study	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78740	Ureteral Reflux Study	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78761	Testicular Imaging With Vascular Flow	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78799	Unlisted genitourinary procedure, diagnostic nuclear medicine	Prior authorization is required.		
78800	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	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78801	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); planar, 2 or more mulitple areas (eg, abdomen and pelvis, head and chest), 1 or more days imaging or single area imaging over 2 or more days	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78802	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); planar, whole body, single day imaging	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78803	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); tomographic (SPECT) , single area (eg, head, neck, chest, pelvis), single day imaging	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78804	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); planar, whole body, requiring 2 or more days imaging	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78830	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); tomographic (SPECT) with concurrently acquired computed tomography (CT) transmission scan for anatomical review, localization and determination/detection of pathology, single area (eg, head, neck, chest, pelvis), single day imaging	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78831	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); tomographic (SPECT), minimum 2 areas (eg, pelvis and knees, abdomen and pelvis), single day imaging, or single area imaging over 2 or more days	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78832	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); tomographic (SPECT) with concurrently acquired computed tomography (CT) transmission scan for anatomical review, localization and determination/detection of pathology, minimum 2 areas (eg, pelvis and knees, abdomen and pelvis), single day imaging, or single area imaging over 2 or more days	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78999	Unlisted procedure, diagnostic nuclear medicine-radiation therapy treatment planning	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
79999	Radiophamaceutical Therapy	Prior authorization is required.		
81099	Unlisted procedure: Urinalysis	Prior authorization is required.		
81105	Human Platelet Antigen 1 genotyping (HPA-1), ITGB3 (integrin, beta 3 [platelet glycoprotein IIIa], antigen CD61 [GPIIIa]) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura), gene analysis, common variant, HPA-1a/b (L33P)	Prior authorization is required.		

81106	Human Platelet Antigen 2 genotyping (HPA-2), GP1BA (glycoprotein Ib [platelet], alpha polypeptide [GPIba]) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura), gene analysis, common variant, HPA-2a/b (T145M)	Prior authorization is required.		
81107	Human Platelet Antigen 3 genotyping (HPA-3), ITGA2B (integrin, alpha 2b [platelet glycoprotein IIb of IIb/IIIa complex], antigen CD41 [GPIIb]) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura), gene analysis, common variant, HPA-3a/b (I843S)	Prior authorization is required.		
81108	Human Platelet Antigen 4 genotyping (HPA-4), ITGB3 (integrin, beta 3 [platelet glycoprotein IIIa], antigen CD61 [GPIIIa]) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura), gene analysis, common variant, HPA-4a/b (R143Q) Open display settings windowGoto the previous code Go to the next codePrint Code Information CPT® Code Set	Prior authorization is required.		
81109	Human Platelet Antigen 5 genotyping (HPA-5), ITGA2 (integrin, alpha 2 [CD49B, alpha 2 subunit of VLA-2 receptor] [GPIa]) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura), gene analysis, common variant (eg, HPA-5a/b [K505E])	Prior authorization is required.		
81110	Human Platelet Antigen 6 genotyping (HPA-6w), ITGB3 (integrin, beta 3 [platelet glycoprotein IIIa, antigen CD61] [GPIIIa]) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura), gene analysis, common variant, HPA-6a/b (R489Q)	Prior authorization is required.		
81111	Human Platelet Antigen 9 genotyping (HPA-9w), ITGA2B (integrin, alpha 2b [platelet glycoprotein IIb of IIb/IIIa complex, antigen CD41] [GPIIb]) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura), gene analysis, common variant, HPA-9a/b (V837M)	Prior authorization is required.		
81112	Human Platelet Antigen 15 genotyping (HPA-15), CD109 (CD109 molecule) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura), gene analysis, common variant, HPA-15a/b (S682Y)	Prior authorization is required.		
81120	IDH1 (isocitrate dehydrogenase 1 [NADP+], soluble) (eg, glioma), common variants (eg, R132H, R132C)	Prior authorization is required.		
81121	IDH2 (isocitrate dehydrogenase 2 [NADP+], mitochondrial) (eg, glioma), common variants (eg, R140W, R172M)	Prior authorization is required.		
81161	DMD (dystrophin) (eg, Duchenne/Becker muscular dystrophy) deletion analysis and duplication analysis, if performed	Prior authorization is required.		
81162	BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis and full duplication/deletion analysis (ie, detection of large gene rearrangements)	Prior authorization is required. Reference policies for additional information.		
81163	BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1250 BRCA1 & BRCA2 Genetic Mutation Testing and Related Genetic Counseling	
81164	BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; full duplication/deletion analysis (ie, detection of large gene rearrangements)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1250 BRCA1 & BRCA2 Genetic Mutation Testing and Related Genetic Counseling	
81165	BRCA1 (BRCA1, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1250 BRCA1 & BRCA2 Genetic Mutation Testing and Related Genetic Counseling	
81166	BRCA1 (BRCA1, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; full duplication/deletion analysis (ie, detection of large gene rearrangements)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1250 BRCA1 & BRCA2 Genetic Mutation Testing and Related Genetic Counseling	
81167	BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; full duplication/deletion analysis (ie, detection of large gene rearrangements)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1250 BRCA1 & BRCA2 Genetic Mutation Testing and Related Genetic Counseling	
81168	CCND1/IGH (t(11;14)) (eg, mantle cell lymphoma) translocation analysis, major breakpoint, qualitative and quantitative, if performed	Prior authorization is required.		
81170	ABL1 (ABL proto-oncogene 1, non-receptor tyrosine kinase) (eg, acquired imatinib tyrosine kinase inhibitor resistance), gene analysis, variants in the kinase domain	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1035 BCR-BL1 Testing in Chronic Myeologenous Leukemia	
81171	AFF2 (ALF transcription elongation factor 2 [FMR2]) (eg, fragile X intellectual disability 2 [FRAXE]) gene analysis; evaluation to detect abnormal (eg, expanded) alleles	Prior authorization is required.		
81172	AFF2 (ALF transcription elongation factor 2 [FMR2]) (eg, fragile X intellectual disability 2 [FRAXE]) gene analysis; characterization of alleles (eg, expanded size and methylation status)	Prior authorization is required.		
81173	AR (androgen receptor) (eg, spinal and bulbar muscular atrophy, Kennedy disease, X chromosome inactivation) gene analysis; full gene sequence	Prior authorization is required.		
81174	AR (androgen receptor) (eg, spinal and bulbar muscular atrophy, Kennedy disease, X chromosome inactivation) gene analysis; known familial variant	Prior authorization is required.		
81175	ASXL1 (additional sex combs like 1, transcriptional regulator) (eg, myelodysplastic syndrome, myeloproliferative neoplasms, chronic myelomonocytic leukemia), gene analysis; full gene sequence	Prior authorization is required.		
81176	ASXL1 (additional sex combs like 1, transcriptional regulator) (eg, myelodysplastic syndrome, myeloproliferative neoplasms, chronic myelomonocytic leukemia), gene analysis; targeted sequence analysis (eg, exon 12)	Prior authorization is required.		
81177	ATN1 (atrophin 1) (eg, dentatorubral-pallidoluysian atrophy) gene analysis, evaluation to detect abnormal (eg, expanded) alleles	Prior authorization is required.		
81178	ATXN1 (ataxin 1) (eg, spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (eg, expanded) alleles	Prior authorization is required.		
81179	ATXN2 (ataxin 2) (eg, spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (eg, expanded) alleles	Prior authorization is required.		
81180	ATXN3 (ataxin 3) (eg, spinocerebellar ataxia, Machado-Joseph disease) gene analysis, evaluation to detect abnormal (eg, expanded) alleles	Prior authorization is required.		

81181	ATXN7 (ataxin 7) (eg, spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (eg, expanded) alleles	Prior authorization is required.		
81182	ATXN8OS (ATXN8 opposite strand [non-protein coding]) (eg, spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (eg, expanded) alleles	Prior authorization is required.		
81183	ATXN10 (ataxin 10) (eg, spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (eg, expanded) alleles	Prior authorization is required.		
81184	CACNA1A (calcium voltage-gated channel subunit alpha1 A) (eg, spinocerebellar ataxia) gene analysis; evaluation to detect abnormal (eg, expanded) alleles	Prior authorization is required.		
81185	CACNA1A (calcium voltage-gated channel subunit alpha1 A) (eg, spinocerebellar ataxia) gene analysis; full gene sequence	Prior authorization is required.		
81186	CACNA1A (calcium voltage-gated channel subunit alpha1 A) (eg, spinocerebellar ataxia) gene analysis; known familial variant	Prior authorization is required.		
81187	CNBP (CCHC-type zinc finger nucleic acid binding protein) (eg, myotonic dystrophy type 2) gene analysis, evaluation to detect abnormal (eg, expanded) alleles	Prior authorization is required.		
81188	CSTB (cystatin B) (eg, Unverricht-Lundborg disease) gene analysis; evaluation to detect abnormal (eg, expanded) alleles	Prior authorization is required.		
81189	CSTB (cystatin B) (eg, Unverricht-Lundborg disease) gene analysis; full gene sequence	Prior authorization is required.		
81190	CSTB (cystatin B) (eg, Unverricht-Lundborg disease) gene analysis; known familial variant(s)	Prior authorization is required.		
81191	NTRK1 (neurotrophic receptor tyrosine kinase 1) (eg, solid tumors) translocation analysis	Prior authorization is required.		
81192	NTRK2 (neurotrophic receptor tyrosine kinase 2) (eg, solid tumors) translocation analysis	Prior authorization is required.		
81193	NTRK3 (neurotrophic receptor tyrosine kinase 3) (eg, solid tumors) translocation analysis	Prior authorization is required.		
81194	NTRK (neurotrophic receptor tyrosine kinase 1, 2 and 3) (eg, solid tumors) translocation analysis	Prior authorization is required.		
81200	ASPA (aspartoacylase) (eg, Canavan disease) gene analysis, common variants (eg, E285A, Y231X)	Prior authorization is required.		
81201	APC (adenomatous polyposis coli) (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; full gene sequence	Prior authorization is required.		
81202	APC (adenomatous polyposis coli) (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; known familial variants	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1207 Genetic Testing for Colorectal Cancer Susceptibility	
81203	APC (adenomatous polyposis coli) (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; duplication/deletion variants	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1207 Genetic Testing for Colorectal Cancer Susceptibility	
81204	AR (androgen receptor) (eg, spinal and bulbar muscular atrophy, Kennedy disease, X chromosome inactivation) gene analysis; characterization of alleles (eg, expanded size or methylation status)	Prior authorization is required.		
81205	BCKDHB (branched-chain keto acid dehydrogenase E1, beta polypeptide) (eg, maple syrup urine disease) gene analysis, common variants (eg, R183P, G278S, E422X)	Prior authorization is required.		
81206	BCR/ABL1 (t(9;22)) (eg, chronic myelogenous leukemia) translocation analysis; major breakpoint, qualitative or quantitative	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1035 BCR-BL1 Testing in Chronic Myeologenous Leukemia	
81207	BCR/ABL1 (t(9;22)) (eg, chronic myelogenous leukemia) translocation analysis; minor breakpoint, qualitative or quantitative	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1035 BCR-BL1 Testing in Chronic Myeologenous Leukemia	
81208	BCR/ABL1 (t(9;22)) (eg, chronic myelogenous leukemia) translocation analysis; other breakpoint, qualitative or quantitative	Prior authorization is required.		
81209	BLM (Bloom syndrome, RecQ helicase-like) (eg, Bloom syndrome) gene analysis, 2281del6ins7 variant	Prior authorization is required.		
81210	BRAF (B-Raf proto-oncogene, serine/threonine kinase) (eg, colon cancer, melanoma), gene analysis, V600 variant(s)	Prior authorization is required.		
81212	BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; 185delAG, 5385insC, 6174delT variants	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1250 BRCA1 & BRCA2 Genetic Mutation Testing and Related Genetic Counseling	
81215	BRCA1 (BRCA1, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; known familial variant	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1250 BRCA1 & BRCA2 Genetic Mutation Testing and Related Genetic Counseling	
81216	BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1250 BRCA1 & BRCA2 Genetic Mutation Testing and Related Genetic Counseling	
81217	BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; known familial variant	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1250 BRCA1 & BRCA2 Genetic Mutation Testing and Related Genetic Counseling	
81218	CEBPA (CCAAT/enhancer binding protein [C/EBP], alpha) (eg, acute myeloid leukemia), gene analysis, full gene sequence	Prior authorization is required.		
81219	CALR (calreticulin) (eg, myeloproliferative disorders), gene analysis, common variants in exon 9	Prior authorization is required.		
81220	CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; common variants (eg, ACMG/ACOG guidelines)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1002 Pharmacogenomic Testing	
81221	CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; known familial variants	Prior authorization is required.		
81222	CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; duplication/deletion variants	Prior authorization is required.		
81223	CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; full gene sequence	Prior authorization is required.		
81224	CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; intron 8 poly-T analysis (eg, male infertility)	Prior authorization is required.		

81225	CYP2C19 (cytochrome P450, family 2, subfamily C, polypeptide 19) (eg, drug metabolism), gene analysis, common variants (eg, *2, *3, *4, *8, *17)	Prior authorization is required.		
81226	CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (eg, drug metabolism), gene analysis, common variants (eg, *2, *3, *4, *5, *6, *9, *10, *17, *19, *29, *35, *41, *1XN, *2XN, *4XN)	Prior authorization is required.		
81227	CYP2C9 (cytochrome P450, family 2, subfamily C, polypeptide 9) (eg, drug metabolism), gene analysis, common variants (eg, *2, *3, *5, *6)	Prior authorization is required.		
81228	Cytogenomic (genome-wide) analysis for constitutional chromosomal abnormalities; interrogation of genomic regions for copy number variants, comparative genomic hybridization [CGH] microarray analysis	Prior authorization is required.		
81229	Cytogenomic (genome-wide) analysis for constitutional chromosomal abnormalities; interrogation of genomic regions for copy number and single nucleotide polymorphism (SNP) variants, comparative genomic hybridization (CGH) microarray analysis	Prior authorization is required.		
81230	CYP3A4 (cytochrome P450 family 3 subfamily A member 4) (eg, drug metabolism), gene analysis, common variant(s) (eg, 2, 22)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1002 Pharmacogenomic Testing	
81231	CYP3A5 (cytochrome P450 family 3 subfamily A member 5) (eg, drug metabolism), gene analysis, common variants (eg, 2, 3, 4, 5, 6, 7)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1002 Pharmacogenomic Testing	
81232	DPYD (dihydropyrimidine dehydrogenase) (eg, 5-fluorouracil/5-FU and capecitabine drug metabolism), gene analysis, common variant(s) (eg, 2A, 4, 5, 6)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1002 Pharmacogenomic Testing	
81233	BTK (Bruton's tyrosine kinase) (eg, chronic lymphocytic leukemia) gene analysis, common variants (eg, C481S, C481R, C481F)	Prior authorization is required.		
81234	DMPK (DM1 protein kinase) (eg, myotonic dystrophy type 1) gene analysis; evaluation to detect abnormal (expanded) alleles	Prior authorization is required.		
81235	EGFR (epidermal growth factor receptor) (eg, non-small cell lung cancer) gene analysis, common variants (eg, exon 19 LREA deletion, L858R, T790M, G719A, G719S, L861Q)	Prior authorization is required.		
81236	EZH2 (enhancer of zeste 2 polycomb repressive complex 2 subunit) (eg, myelodysplastic syndrome, myeloproliferative neoplasms) gene analysis, full gene sequence	Prior authorization is required.		
81237	EZH2 (enhancer of zeste 2 polycomb repressive complex 2 subunit) (eg, diffuse large B-cell lymphoma) gene analysis, common variant(s) (eg, codon 646)	Prior authorization is required.		
81238	F9 (coagulation factor IX) (eg, hemophilia B), full gene sequence	Prior authorization is required.		
81239	DMPK (DM1 protein kinase) (eg, myotonic dystrophy type 1) gene analysis; characterization of alleles (eg, expanded size)	Prior authorization is required.		
81240	F2 (prothrombin, coagulation factor II) (eg, hereditary hypercoagulability) gene analysis, 20210G>A variant	Prior authorization is required.		
81241	F5 (coagulation factor V) (eg, hereditary hypercoagulability) gene analysis, Leiden variant	Prior authorization is required.		
81242	FANCC (Fanconi anemia, complementation group C) (eg, Fanconi anemia, type C) gene analysis, common variant (eg, IVS4+4A>T)	Prior authorization is required.		
81243	FMR1 (fragile X messenger ribonucleoprotein 1) (eg, fragile X syndrome, X-linked intellectual disability [XLID]) gene analysis; evaluation to detect abnormal (eg, expanded) alleles	Prior authorization is required.		
81244	FMR1 (fragile X messenger ribonucleoprotein 1) (eg, fragile X syndrome, X-linked intellectual disability [XLID]) gene analysis; characterization of alleles (eg, expanded size and promoter methylation status)	Prior authorization is required.		
81245	FLT3 (fms-related tyrosine kinase 3) (eg, acute myeloid leukemia), gene analysis; internal tandem duplication (ITD) variants (ie, exons 14, 15)	Prior authorization is required.		
81246	FLT3 (fms-related tyrosine kinase 3) (eg, acute myeloid leukemia), gene analysis; tyrosine kinase domain (TKD) variants (eg, D835, I836)	Prior authorization is required.		
81247	G6PD (glucose-6-phosphate dehydrogenase) (eg, hemolytic anemia, jaundice), gene analysis; common variant(s) (eg, A, A-)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1002 Pharmacogenomic Testing	
81248	G6PD (glucose-6-phosphate dehydrogenase) (eg, hemolytic anemia, jaundice), gene analysis; known familial variant(s)	Prior authorization is required.		
81249	G6PD (glucose-6-phosphate dehydrogenase) (eg, hemolytic anemia, jaundice), gene analysis; full gene sequence	Prior authorization is required.		
81250	G6PC (glucose-6-phosphatase, catalytic subunit) (eg, Glycogen storage disease, type 1a, von Gierke disease) gene analysis, common variants (eg, R83C, Q347X)	Prior authorization is required.		
81251	GBA (glucosidase, beta, acid) (eg, Gaucher disease) gene analysis, common variants (eg, N370S, 84GG, L444P, IVS2+1G>A)	Prior authorization is required.		
81252	GJB2 (gap junction protein, beta 2, 26kDa, connexin 26) (eg, nonsyndromic hearing loss) gene analysis; full gene sequence	Prior authorization is required.		
81253	GJB2 (gap junction protein, beta 2, 26kDa, connexin 26) (eg, nonsyndromic hearing loss) gene analysis; known familial variants	Prior authorization is required.		
81254	GJB6 (gap junction protein, beta 6, 30kDa, connexin 30) (eg, nonsyndromic hearing loss) gene analysis, common variants (eg, 309kb [del(GJB6-D13S1830)] and 232kb [del(GJB6-D13S1854)])	Prior authorization is required.		
81255	HEXA (hexosaminidase A [alpha polypeptide]) (eg, Tay-Sachs disease) gene analysis, common variants (eg, 1278insTATC, 1421+1G>C, G269S)	Prior authorization is required.		
81256	HFE (hemochromatosis) (eg, hereditary hemochromatosis) gene analysis, common variants (eg, C282Y, H63D)	Prior authorization is required.		
81257	HBA1/HBA2 (alpha globin 1 and alpha globin 2) (eg, alpha thalassemia, Hb Bart hydrops fetalis syndrome, HbH disease), gene analysis; common deletions or variant (eg, Southeast Asian, Thai, Filipino, Mediterranean, alpha3.7, alpha4.2, alpha20.5, Constant Spring)	Prior authorization is required.		

81258	HBA1/HBA2 (alpha globin 1 and alpha globin 2) (eg, alpha thalassemia, Hb Bart hydrops fetalis syndrome, HbH disease), gene analysis; known familial variant	Prior authorization is required.		
81259	HBA1/HBA2 (alpha globin 1 and alpha globin 2) (eg, alpha thalassemia, Hb Bart hydrops fetalis syndrome, HbH disease), gene analysis; full gene sequence	Prior authorization is required.		
81260	IKBKAP (inhibitor of kappa light polypeptide gene enhancer in B-cells, kinase complex-associated protein) (eg, familial dysautonomia) gene analysis, common variants (eg, 2507+6T>C, R696P)	Prior authorization is required.		
81261	IGH@ (Immunoglobulin heavy chain locus) (eg, leukemias and lymphomas, B-cell), gene rearrangement analysis to detect abnormal clonal population(s); amplified methodology (eg, polymerase chain reaction)	Prior authorization is required.		
81262	IGH@ (Immunoglobulin heavy chain locus) (eg, leukemias and lymphomas, B-cell), gene rearrangement analysis to detect abnormal clonal population(s); direct probe methodology (eg, Southern blot)	Prior authorization is required.		
81263	IGH@ (Immunoglobulin heavy chain locus) (eg, leukemia and lymphoma, B-cell), variable region somatic mutation analysis	Prior authorization is required.		
81264	IGK@ (Immunoglobulin kappa light chain locus) (eg, leukemia and lymphoma, B-cell), gene rearrangement analysis, evaluation to detect abnormal clonal population(s)	Prior authorization is required.		
81265	Comparative analysis using Short Tandem Repeat (STR) markers; patient and comparative specimen (eg, pre-transplant recipient and donor germline testing, post-transplant non-hematopoietic recipient germline [eg, buccal swab or other germline tissue sample] and donor testing, twin zygosity testing, or maternal cell contamination of fetal cells)	Prior authorization is required.		
81266	Comparative analysis using Short Tandem Repeat (STR) markers; each additional specimen (eg, additional cord blood donor, additional fetal samples from different cultures, or additional zygosity in multiple birth pregnancies) (List separately in addition to code for primary procedure)	Prior authorization is required.		
81267	Chimerism (engraftment) analysis, post transplantation specimen (eg, hematopoietic stem cell), includes comparison to previously performed baseline analyses; without cell selection	Prior authorization is required.		
81268	Chimerism (engraftment) analysis, post transplantation specimen (eg, hematopoietic stem cell), includes comparison to previously performed baseline analyses; with cell selection (eg, CD3, CD33), each cell type	Prior authorization is required.		
81269	HBA1/HBA2 (alpha globin 1 and alpha globin 2) (eg, alpha thalassemia, Hb Bart hydrops fetalis syndrome, HbH disease), gene analysis; duplication/deletion variants	Prior authorization is required.		
81270	JAK2 (Janus kinase 2) (eg, myeloproliferative disorder) gene analysis, p.Val617Phe (V617F) variant	Prior authorization is required.		
81271	HTT (huntingtin) (eg, Huntington disease) gene analysis; evaluation to detect abnormal (eg, expanded) alleles	Prior authorization is required.		
81272	KIT (v-kit Hardy-Zuckerman 4 feline sarcoma viral oncogene homolog) (eg, gastrointestinal stromal tumor [GIST], acute myeloid leukemia, melanoma), gene analysis, targeted sequence analysis (eg, exons 8, 11, 13, 17, 18)	Prior authorization is required.		
81273	KIT (v-kit Hardy-Zuckerman 4 feline sarcoma viral oncogene homolog) (eg, mastocytosis), gene analysis, D816 variant(s)	Prior authorization is required.		
81274	HTT (huntingtin) (eg, Huntington disease) gene analysis; characterization of alleles (eg, expanded size)	Prior authorization is required.		
81275	KRAS (Kirsten rat sarcoma viral oncogene homolog) (eg, carcinoma) gene analysis; variants in exon 2 (eg, codons 12 and 13)	Prior authorization is required.		
81276	KRAS (Kirsten rat sarcoma viral oncogene homolog) (eg, carcinoma) gene analysis; additional variant(s) (eg, codon 61, codon 146)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1028 Molecular Tumor Markers for Non-Small Lung Cancer	
81277	Cytogenomic neoplasia (genome-wide) microarray analysis, interrogation of genomic regions for copy number and loss-of-heterozygosity variants for chromosomal abnormalities	Prior authorization is required.		
81278	IGH@/BCL2 (t(14;18)) (eg, follicular lymphoma) translocation analysis, major breakpoint region (MBR) and minor cluster region (mcr) breakpoints, qualitative or quantitative	Prior authorization is required.		
81279	JAK2 (Janus kinase 2) (eg, myeloproliferative disorder) targeted sequence analysis (eg, exons 12 and 13)	Prior authorization is required.		
81283	IFNL3 (interferon, lambda 3) (eg, drug response), gene analysis, rs12979860 variant	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1002 Pharmacogenomic Testing	
81284	FXN (frataxin) (eg, Friedreich ataxia) gene analysis; evaluation to detect abnormal (expanded) alleles	Prior authorization is required.		
81285	FXN (frataxin) (eg, Friedreich ataxia) gene analysis; characterization of alleles (eg, expanded size)	Prior authorization is required.		
81286	FXN (frataxin) (eg, Friedreich ataxia) gene analysis; full gene sequence	Prior authorization is required.		
81287	MGMT (O-6-methylguanine-DNA methyltransferase) (eg, glioblastoma multiforme) promoter methylation analysis	Prior authorization is required.		
81288	MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; promoter methylation analysis	Prior authorization is required.		
81289	FXN (frataxin) (eg, Friedreich ataxia) gene analysis; known familial variant(s)	Prior authorization is required.		
81290	MCOLN1 (mucolipin 1) (eg, Mucolipidosis, type IV) gene analysis, common variants (eg, IVS3-2A>G, del6.4kb)	Prior authorization is required.		
81291	MTHFR (5,10-methylenetetrahydrofolate reductase) (eg, hereditary hypercoagulability) gene analysis, common variants (eg, 677T, 1298C)	Prior authorization is required.		

81292	MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis	Prior authorization is required.		
81293	MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants	Prior authorization is required.		
81294	MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants	Prior authorization is required.		
81295	MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis	Prior authorization is required.		
81296	MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants	Prior authorization is required.		
81297	MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants	Prior authorization is required.		
81298	MSH6 (mutS homolog 6 [E. coli]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis	Prior authorization is required.		
81299	MSH6 (mutS homolog 6 [E. coli]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants	Prior authorization is required.		
81300	MSH6 (mutS homolog 6 [E. coli]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants	Prior authorization is required.		
81301	Microsatellite instability analysis (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) of markers for mismatch repair deficiency (eg, BAT25, BAT26), includes comparison of neoplastic and normal tissue, if performed	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1207 Genetic Testing for Colorectal Cancer Susceptibility	
81302	MECP2 (methyl CpG binding protein 2) (eg, Rett syndrome) gene analysis; full sequence analysis	Prior authorization is required.		
81303	MECP2 (methyl CpG binding protein 2) (eg, Rett syndrome) gene analysis; known familial variant	Prior authorization is required.		
81304	MECP2 (methyl CpG binding protein 2) (eg, Rett syndrome) gene analysis; duplication/deletion variants	Prior authorization is required.		
81305	MYD88 (myeloid differentiation primary response 88) (eg, Waldenstrom's macroglobulinemia, lymphoplasmacytic leukemia) gene analysis, p.Leu265Pro (L265P) variant	Prior authorization is required.		
81306	NUDT15 (nudix hydrolase 15) (eg, drug metabolism) gene analysis, common variant(s) (eg, *2, *3, *4, *5, *6)	Prior authorization is required.		
81307	PALB2 (partner and localizer of BRCA2) (eg, breast and pancreatic cancer) gene analysis; full gene sequence	Prior authorization is required.		
81308	PALB2 (partner and localizer of BRCA2) (eg, breast and pancreatic cancer) gene analysis; known familial variant	Prior authorization is required.		
81309	PIK3CA (phosphatidylinositol-4, 5-biphosphate 3-kinase, catalytic subunit alpha) (eg, colorectal and breast cancer) gene analysis, targeted sequence analysis (eg, exons 7, 9, 20)	Prior authorization is required.		
81310	NPM1 (nucleophosmin) (eg, acute myeloid leukemia) gene analysis, exon 12 variants	Prior authorization is required.		
81311	NRAS (neuroblastoma RAS viral [v-ras] oncogene homolog) (eg, colorectal carcinoma), gene analysis, variants in exon 2 (eg, codons 12 and 13) and exon 3 (eg, codon 61)	Prior authorization is required.		
81312	PABPN1 (poly[A] binding protein nuclear 1) (eg, oculopharyngeal muscular dystrophy) gene analysis, evaluation to detect abnormal (eg, expanded) alleles	Prior authorization is required.		
81313	PCA3/KLK3 (prostate cancer antigen 3 [non-protein coding]/kallikrein-related peptidase 3 [prostate specific antigen]) ratio (eg, prostate cancer)	Prior authorization is required.		
81314	PDGFRA (platelet-derived growth factor receptor, alpha polypeptide) (eg, gastrointestinal stromal tumor [GIST]), gene analysis, targeted sequence analysis (eg, exons 12, 18)	Prior authorization is required.		
81315	PML/RARalpha, (t(15;17)), (promyelocytic leukemia/retinoic acid receptor alpha) (eg, promyelocytic leukemia) translocation analysis; common breakpoints (eg, intron 3 and intron 6), qualitative or quantitative	Prior authorization is required.		
81316	PML/RARalpha, (t(15;17)), (promyelocytic leukemia/retinoic acid receptor alpha) (eg, promyelocytic leukemia) translocation analysis; single breakpoint (eg, intron 3, intron 6 or exon 6), qualitative or quantitative	Prior authorization is required.		
81317	PMS2 (postmeiotic segregation increased 2 [S. cerevisiae]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis	Prior authorization is required.		
81318	PMS2 (postmeiotic segregation increased 2 [S. cerevisiae]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants	Prior authorization is required.		
81319	PMS2 (postmeiotic segregation increased 2 [S. cerevisiae]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants	Prior authorization is required.		
81320	PLCG2 (phospholipase C gamma 2) (eg, chronic lymphocytic leukemia) gene analysis, common variants (eg, R665W, S707F, L845F)	Prior authorization is required.		
81321	PTEN (phosphatase and tensin homolog) (eg, Cowden syndrome, PTEN hamartoma tumor syndrome) gene analysis; full sequence analysis	Prior authorization is required.		
81322	PTEN (phosphatase and tensin homolog) (eg, Cowden syndrome, PTEN hamartoma tumor syndrome) gene analysis; known familial variant	Prior authorization is required.		
81323	PTEN (phosphatase and tensin homolog) (eg, Cowden syndrome, PTEN hamartoma tumor syndrome) gene analysis; duplication/deletion variant	Prior authorization is required.		

81324	PMP22 (peripheral myelin protein 22) (eg, Charcot-Marie-Tooth, hereditary neuropathy with liability to pressure palsies) gene analysis; duplication/deletion analysis	Prior authorization is required.		
81325	PMP22 (peripheral myelin protein 22) (eg, Charcot-Marie-Tooth, hereditary neuropathy with liability to pressure palsies) gene analysis; full sequence analysis	Prior authorization is required.		
81326	PMP22 (peripheral myelin protein 22) (eg, Charcot-Marie-Tooth, hereditary neuropathy with liability to pressure palsies) gene analysis; known familial variant	Prior authorization is required.		
81327	SEPT9 (Septin9) (eg, colorectal cancer) promoter methylation analysis	Prior authorization is required.		
81328	SLCO1B1 (solute carrier organic anion transporter family, member 1B1) (eg, adverse drug reaction), gene analysis, common variant(s) (eg, 5)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1002 Pharmacogenomic Testing	
81329	SMN1 (survival of motor neuron 1, telomeric) (eg, spinal muscular atrophy) gene analysis; dosage/deletion analysis (eg, carrier testing), includes SMN2 (survival of motor neuron 2, centromeric) analysis, if performed	Prior authorization is required.		
81330	SMPD1 (sphingomyelin phosphodiesterase 1, acid lysosomal) (eg, Niemann-Pick disease, Type A) gene analysis, common variants (eg, R496L, L302P, fsP330)	Prior authorization is required.		
81331	SNRPN/UBE3A (small nuclear ribonucleoprotein polypeptide N and ubiquitin protein ligase E3A) (eg, Prader-Willi syndrome and/or Angelman syndrome), methylation analysis	Prior authorization is required.		
81332	SERPINA1 (serpin peptidase inhibitor, clade A, alpha-1 antiproteinase, antitrypsin, member 1) (eg, alpha-1-antitrypsin deficiency), gene analysis, common variants (eg, *S and *Z)	Prior authorization is required.		
81333	TGFBI (transforming growth factor beta-induced) (eg, corneal dystrophy) gene analysis, common variants (eg, R124H, R124C, R124L, R555W, R555Q)	Prior authorization is required.		
81334	RUNX1 (runt related transcription factor 1) (eg, acute myeloid leukemia, familial platelet disorder with associated myeloid malignancy) gene analysis, targeted sequence analysis (eg, exons 3-8)	Prior authorization is required.		
81335	TPMT (thiopurine S-methyltransferase) (eg, drug metabolism), gene analysis, common variants (eg, 2, 3)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1002 Pharmacogenomic Testing	
81336	SMN1 (survival of motor neuron 1, telomeric) (eg, spinal muscular atrophy) gene analysis; full gene sequence	Prior authorization is required.		
81337	SMN1 (survival of motor neuron 1, telomeric) (eg, spinal muscular atrophy) gene analysis; known familial sequence variant(s)	Prior authorization is required.		
81338	MPL (MPL proto-oncogene, thrombopoietin receptor) (eg, myeloproliferative disorder) gene analysis; common variants (eg, W515A, W515K, W515L, W515R)	Prior authorization is required.		
81339	MPL (MPL proto-oncogene, thrombopoietin receptor) (eg, myeloproliferative disorder) gene analysis; sequence analysis, exon 10	Prior authorization is required.		
81340	TRB@ (T cell antigen receptor, beta) (eg, leukemia and lymphoma), gene rearrangement analysis to detect abnormal clonal population(s); using amplification methodology (eg, polymerase chain reaction)	Prior authorization is required.		
81341	TRB@ (T cell antigen receptor, beta) (eg, leukemia and lymphoma), gene rearrangement analysis to detect abnormal clonal population(s); using direct probe methodology (eg, Southern blot)	Prior authorization is required.		
81342	TRG@ (T cell antigen receptor, gamma) (eg, leukemia and lymphoma), gene rearrangement analysis, evaluation to detect abnormal clonal population(s)	Prior authorization is required.		
81343	PPP2R2B (protein phosphatase 2 regulatory subunit Bbeta) (eg, spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (eg, expanded) alleles	Prior authorization is required.		
81344	TBP (TATA box binding protein) (eg, spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (eg, expanded) alleles	Prior authorization is required.		
81345	TERT (telomerase reverse transcriptase) (eg, thyroid carcinoma, glioblastoma multiforme) gene analysis, targeted sequence analysis (eg, promoter region)	Prior authorization is required.		
81346	TYMS (thymidylate synthetase) (eg, 5-fluorouracil/5-FU drug metabolism), gene analysis, common variant(s) (eg, tandem repeat variant)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1002 Pharmacogenomic Testing	
81350	UGT1A1 (UDP glucuronosyltransferase 1 family, polypeptide A1) (eg, drug metabolism, hereditary unconjugated hyperbilirubinemia [Gilbert syndrome]) gene analysis, common variants (eg, *28, *36, *37)	Prior authorization is required.		
81351	TP53 (tumor protein 53) (eg, Li-Fraumeni syndrome) gene analysis; full gene sequence	Prior authorization is required.		
81353	TP53 (tumor protein 53) (eg, Li-Fraumeni syndrome) gene analysis; known familial variant	Prior authorization is required.		
81355	VKORC1 (vitamin K epoxide reductase complex, subunit 1) (eg, warfarin metabolism), gene analysis, common variant(s) (eg, -1639G>A, c.173+1000C>T)	Prior authorization is required.		
81361	HBB (hemoglobin, subunit beta) (eg, sickle cell anemia, beta thalassemia, hemoglobinopathy); common variant(s) (eg, HbS, HbC, HbE)	Prior authorization is required.		
81362	HBB (hemoglobin, subunit beta) (eg, sickle cell anemia, beta thalassemia, hemoglobinopathy); known familial variant(s)	Prior authorization is required.		
81363	HBB (hemoglobin, subunit beta) (eg, sickle cell anemia, beta thalassemia, hemoglobinopathy); duplication/deletion variant(s)	Prior authorization is required.		
81364	HBB (hemoglobin, subunit beta) (eg, sickle cell anemia, beta thalassemia, hemoglobinopathy); full gene sequence	Prior authorization is required.		
81370	HLA Class I and II typing, low resolution (eg, antigen equivalents); HLA-A, -B, -C, -DRB1/3/4/5 and -DQB1	Prior authorization is required.		
81371	HLA Class I and II typing, low resolution (eg, antigen equivalents); HLA-A, -B and -DRB1 (eg, verification typing)	Prior authorization is required.		
81372	HLA Class I typing, low resolution (eg, antigen equivalents); complete (ie, HLA-A, -B and -C)	Prior authorization is required.		

81373	HLA Class I typing, low resolution (eg, antigen equivalents); one locus (eg, HLA-A, -B, or -C), each	Prior authorization is required.		
81374	HLA Class I typing, low resolution (eg, antigen equivalents); one antigen equivalent (eg, B*27), each	Prior authorization is required.		
81375	HLA Class II typing, low resolution (eg, antigen equivalents); HLA-DRB1/3/4/5 and -DQB1	Prior authorization is required.		
81376	HLA Class II typing, low resolution (eg, antigen equivalents); one locus (eg, HLA-DRB1, -DRB3/4/5, -DQB1, -DQA1, -DPB1, or -DPA1), each	Prior authorization is required.		
81377	HLA Class II typing, low resolution (eg, antigen equivalents); one antigen equivalent, each	Prior authorization is required.		
81378	HLA Class I and II typing, high resolution (ie, alleles or allele groups), HLA-A, -B, -C and -DRB1	Prior authorization is required.		
81379	HLA Class I typing, high resolution (ie, alleles or allele groups); complete (ie, HLA-A, -B and -C)	Prior authorization is required.		
81380	HLA Class I typing, high resolution (ie, alleles or allele groups); one locus (eg, HLA-A, -B, or -C), each	Prior authorization is required.		
81381	HLA Class I typing, high resolution (ie, alleles or allele groups); one allele or allele group (eg, B*57:01P), each	Prior authorization is required.		
81382	HLA Class II typing, high resolution (ie, alleles or allele groups); one locus (eg, HLA-DRB1, -DRB3/4/5, -DQB1, -DQA1, -DPB1, or -DPA1), each	Prior authorization is required.		
81383	HLA Class II typing, high resolution (ie, alleles or allele groups); one allele or allele group (eg, HLA-DQB1*06:02P), each	Prior authorization is required.		
81400	Molecular pathology procedure, Level 1 (eg, identification of single germline variant [eg, SNP] by techniques such as restriction enzyme digestion or melt curve analysis) ACADM (acyl-CoA dehydrogenase, C-4 to C-12 straight chain, MCAD) (eg, medium chain acyl dehydrogenase deficiency), K304E variant ACE (angiotensin converting enzyme) (eg, hereditary blood pressure regulation), insertion/deletion variant AGTR1 (angiotensin II receptor, type 1) (eg, essential hypertension), 1166A>C variant BCKDHA (branched chain keto acid dehydrogenase E1, alpha polypeptide) (eg, maple syrup urine disease, type	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1210 Oncologic Genetic Testing Panels	
81401	Molecular pathology procedure, Level 2 (eg, 2-10 SNPs, 1 methylated variant, or 1 somatic variant [typically using nonsequencing target variant analysis], or detection of a dynamic mutation disorder/triplet repeat) ABCC8 (ATP-binding cassette, sub-family C [CFTR/MRP], member 8) (eg, familial hyperinsulinism), common variants (eg, c.3898-9G>A [c.3992-9G>A], F1388del) ABL1 (ABL proto-oncogene 1, non-receptor tyrosine kinase) (eg, acquired imatinib resistance), T315I variant ACADM (acyl-CoA dehydrogenase, C-4 to C-12 straight chain, MCAD) (eg, medium chain acyl dehydrogenase deficiency), commons	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1207 Genetic Testing for Colorectal Cancer Susceptibility and HHO-DE-MP-1210 Oncologic Genetic Testing Panels	
81402	Molecular pathology procedure, Level 3 (eg, >10 SNPs, 2-10 methylated variants, or 2-10 somatic variants [typically using non-sequencing target variant analysis], immunoglobulin and T-cell receptor gene rearrangements, duplication/deletion variants of 1 exon, loss of heterozygosity [LOH], uniparental disomy [UPD]) Chromosome 1p-/19q- (eg, glial tumors), deletion analysis Chromosome 18q- (eg, D18S55, D18S58, D18S61, D18S64 and D18S69) (eg, colon cancer), allelic imbalance assessment (ie, loss of heterozygosity) COL1A1/PDGFB (t(17;22)) (eg, dermatofibrosarcoma protuberans), translocation analys	Prior authorization is required.		
81403	Molecular pathology procedure, Level 4 (eg, analysis of single exon by DNA sequence analysis, analysis of >10 amplicons using multiplex PCR in 2 or more independent reactions, mutation scanning or duplication/deletion variants of 2-5 exons) ANG (angiogenin, ribonuclease, RNase A family, 5) (eg, amyotrophic lateral sclerosis), full gene sequence ARX (aristaless-related homeobox) (eg, X-linked lissencephaly with ambiguous genitalia, X-linked mental retardation), duplication/deletion analysis CEL (carboxyl ester lipase [bile salt-stimulated lipase]) (eg, maturity-onset diabetes of the young [MODY	Prior authorization is required.		
81404	Molecular pathology procedure, Level 5 (eg, analysis of 2-5 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 6-10 exons, or characterization of a dynamic mutation disorder/triplet repeat by Southern blot analysis) ACADS (acyl-CoA dehydrogenase, C-2 to C-3 short chain) (eg, short chain acyl-CoA dehydrogenase deficiency), targeted sequence analysis (eg, exons 5 and 6) AQP2 (aquaporin 2 [collecting duct]) (eg, nephrogenic diabetes insipidus), full gene sequence ARX (aristaless related homeobox) (eg, X-linked lissencephaly with ambiguous genitalia, X-linked men	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1210 Oncologic Genetic Testing Panels and HHO-DE-MP-1028 Molecular Tumor Markers for Non-Small Lung Cancer	
81405	Molecular pathology procedure, Level 6 (eg, analysis of 6-10 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 11-25 exons, regionally targeted cytogenomic array analysis) ABCD1 (ATP-binding cassette, sub-family D [ALD], member 1) (eg, adrenoleukodystrophy), full gene sequence ACADS (acyl-CoA dehydrogenase, C-2 to C-3 short chain) (eg, short chain acyl-CoA dehydrogenase deficiency), full gene sequence ACTA2 (actin, alpha 2, smooth muscle, aorta) (eg, thoracic aortic aneurysms and aortic dissections), full gene sequence ACTC1 (actin, alpha, cardiac muscle 1)	Prior authorization is required.		

81406	Molecular pathology procedure, Level 7 (eg, analysis of 11-25 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 26-50 exons) ACADVL (acyl-CoA dehydrogenase, very long chain) (eg, very long chain acyl-coenzyme A dehydrogenase deficiency), full gene sequence ACTN4 (actinin, alpha 4) (eg, focal segmental glomerulosclerosis), full gene sequence AFG3L2 (AFG3 ATPase family gene 3-like 2 [S. cerevisiae]) (eg, spinocerebellar ataxia), full gene sequence AIRE (autoimmune regulator) (eg, autoimmune polyendocrinopathy syndrome type 1), full gene sequence ALDH7A1 (aldeh	Prior authorization is required.		
81407	Molecular pathology procedure, Level 8 (eg, analysis of 26-50 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of >50 exons, sequence analysis of multiple genes on one platform) ABCC8 (ATP-binding cassette, sub-family C [CFTR/MRP], member 8) (eg, familial hyperinsulinism), full gene sequence AGL (amylo-alpha-1, 6-glucosidase, 4-alpha-glucanotransferase) (eg, glycogen storage disease type III), full gene sequence AHI1 (Abelson helper integration site 1) (eg, Joubert syndrome), full gene sequence APOB (apolipoprotein B) (eg, familial hypercholesterolemia type B)	Prior authorization is required.		
81408	Molecular pathology procedure, Level 9 (eg, analysis of >50 exons in a single gene by DNA sequence analysis) ABCA4 (ATP-binding cassette, sub-family A [ABC1], member 4) (eg, Stargardt disease, age-related macular degeneration), full gene sequence ATM (ataxia telangiectasia mutated) (eg, ataxia telangiectasia), full gene sequence CDH23 (cadherin-related 23) (eg, Usher syndrome, type 1), full gene sequence CEP290 (centrosomal protein 290kDa) (eg, Joubert syndrome), full gene sequence COL1A1 (collagen, type I, alpha 1) (eg, osteogenesis imperfecta, type I), full gene sequence COL1A2 (collagen, ty	Prior authorization is required.		
81410	Aortic dysfunction or dilation (eg, Marfan syndrome, Loeys Dietz syndrome, Ehler Danlos syndrome type IV, arterial tortuosity syndrome); genomic sequence analysis panel, must include sequencing of at least 9 genes, including FBN1, TGFBR1, TGFBR2, COL3A1, MYH11, ACTA2, SLC2A10, SMAD3 and MYLK	Prior authorization is required.		
81411	Aortic dysfunction or dilation (eg, Marfan syndrome, Loeys Dietz syndrome, Ehler Danlos syndrome type IV, arterial tortuosity syndrome); duplication/deletion analysis panel, must include analyses for TGFBR1, TGFBR2, MYH11 and COL3A1	Prior authorization is required.		
81412	Ashkenazi Jewish associated disorders (eg, Bloom syndrome, Canavan disease, cystic fibrosis, familial dysautonomia, Fanconi anemia group C, Gaucher disease, Tay-Sachs disease), genomic sequence analysis panel, must include sequencing of at least 9 genes, including ASPA, BLM, CFTR, FANCC, GBA, HEXA, IKBKAP, MCOLN1 and SMPD1	Prior authorization is required.		
81413	Cardiac ion channelopathies (eg, Brugada syndrome, long QT syndrome, short QT syndrome, catecholaminergic polymorphic ventricular tachycardia); genomic sequence analysis panel, must include sequencing of at least 10 genes, including ANK2, CASQ2, CAV3, KCNE1, KCNE2, KCNH2, KCNJ2, KCNQ1, RYR2 and SCN5A	Prior authorization is required.		
81414	Cardiac ion channelopathies (eg, Brugada syndrome, long QT syndrome, short QT syndrome, catecholaminergic polymorphic ventricular tachycardia); duplication/deletion gene analysis panel, must include analysis of at least 2 genes, including KCNH2 and KCNQ1	Prior authorization is required.		
81415	Exome (eg, unexplained constitutional or heritable disorder or syndrome); sequence analysis	Prior authorization is required.		
81416	Exome (eg, unexplained constitutional or heritable disorder or syndrome); sequence analysis, each comparator exome (eg, parents, siblings) (List separately in addition to code for primary procedure)	Prior authorization is required.		
81417	Exome (eg, unexplained constitutional or heritable disorder or syndrome); re-evaluation of previously obtained exome sequence (eg, updated knowledge or unrelated condition/syndrome)	Prior authorization is required.		
81419	Epilepsy genomic sequence analysis panel, must include analyses for ALDH7A1, CACNA1A, CDKL5, CHD2, GABRG2, GRIN2A, KCNQ2, MECP2, PCDH19, POLG, PRRT2, SCN1A, SCN1B, SCN2A, SCN8A, SLC2A1, SLC9A6, STXBP1, SYNGAP1, TCF4, TPP1, TSC1, TSC2 and ZEB2	Prior authorization is required.		
81420	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	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1208 Fetal Aneuploidy Testing Using Noninvasive Cell-Free Fetal DNA	
81422	Fetal chromosomal microdeletion(s) genomic sequence analysis (eg, DiGeorge syndrome, Cri-du-chat syndrome), circulating cell-free fetal DNA in maternal blood	Prior authorization is required.		
81425	Genome (eg, unexplained constitutional or heritable disorder or syndrome); sequence analysis	Prior authorization is required.		
81426	Genome (eg, unexplained constitutional or heritable disorder or syndrome); sequence analysis, each comparator genome (eg, parents, siblings) (List separately in addition to code for primary procedure)	Prior authorization is required.		
81427	Genome (eg, unexplained constitutional or heritable disorder or syndrome); re-evaluation of previously obtained genome sequence (eg, updated knowledge or unrelated condition/syndrome)	Prior authorization is required.		
81430	Hearing loss (eg, nonsyndromic hearing loss, Usher syndrome, Pendred syndrome); genomic sequence analysis panel, must include sequencing of at least 60 genes, including CDH23, CLRN1, GJB2, GPR98, MTRNR1, MYO7A, MYO15A, PCDH15, OTOF, SLC26A4, TMC1, TMPRSS3, USH1C, USH1G, USH2A and WFS1	Prior authorization is required.		

81431	Hearing loss (eg, nonsyndromic hearing loss, Usher syndrome, Pendred syndrome); duplication/deletion analysis panel, must include copy number analyses for STRC and DFNB1 deletions in GJB2 and GJB6 genes	Prior authorization is required.		
81432	Hereditary breast cancer-related disorders (eg, hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer); genomic sequence analysis panel, must include sequencing of at least 10 genes, always including BRCA1, BRCA2, CDH1, MLH1, MSH2, MSH6, PALB2, PTEN, STK11 and TP53	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1210 Oncologic Genetic Testing Panels	
81433	Hereditary breast cancer-related disorders (eg, hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer); duplication/deletion analysis panel, must include analyses for BRCA1, BRCA2, MLH1, MSH2 and STK11	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1210 Oncologic Genetic Testing Panels	
81434	Hereditary retinal disorders (eg, retinitis pigmentosa, Leber congenital amaurosis, cone-rod dystrophy), genomic sequence analysis panel, must include sequencing of at least 15 genes, including ABCA4, CNGA1, CRB1, EYS, PDE6A, PDE6B, PRPF31, PRPH2, RDH12, RHO, RP1, RP2, RPE65, RPGR and USH2A	Prior authorization is required.		
81435	Hereditary colon cancer disorders (eg, Lynch syndrome, PTEN hamartoma syndrome, Cowden syndrome, familial adenomatosis polyposis); genomic sequence analysis panel, must include sequencing of at least 10 genes, including APC, BMPR1A, CDH1, MLH1, MSH2, MSH6, MUTYH, PTEN, SMAD4 and STK11	Prior authorization is required.		
81436	Hereditary colon cancer disorders (eg, Lynch syndrome, PTEN hamartoma syndrome, Cowden syndrome, familial adenomatosis polyposis); duplication/deletion analysis panel, must include analysis of at least 5 genes, including MLH1, MSH2, EPCAM, SMAD4 and STK11	Prior authorization is required.		
81437	Hereditary neuroendocrine tumor disorders (eg, medullary thyroid carcinoma, parathyroid carcinoma, malignant pheochromocytoma or paraganglioma); genomic sequence analysis panel, must include sequencing of at least 6 genes, including MAX, SDHB, SDHC, SDHD, TMEM127 and VHL	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1210 Oncologic Genetic Testing Panels	
81438	Hereditary neuroendocrine tumor disorders (eg, medullary thyroid carcinoma, parathyroid carcinoma, malignant pheochromocytoma or paraganglioma); duplication/deletion analysis panel, must include analyses for SDHB, SDHC, SDHD and VHL	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1210 Oncologic Genetic Testing Panels	
81439	Hereditary cardiomyopathy (eg, hypertrophic cardiomyopathy, dilated cardiomyopathy, arrhythmogenic right ventricular cardiomyopathy), genomic sequence analysis panel, must include sequencing of at least 5 cardiomyopathy-related genes (eg, DSG2, MYBPC3, MYH7, PKP2, TTN)	Prior authorization is required.		
81440	Nuclear encoded mitochondrial genes (eg, neurologic or myopathic phenotypes), genomic sequence panel, must include analysis of at least 100 genes, including BCS1L, C10orf2, COQ2, COX10, DGUOK, MPV17, OPA1, PDSS2, POLG, POLG2, RRM2B, SCO1, SCO2, SLC25A4, SUCLA2, SUCLG1, TAZ, TK2 and TYMP	Prior authorization is required.		
81442	Noonan spectrum disorders (eg, Noonan syndrome, cardio-facio-cutaneous syndrome, Costello syndrome, LEOPARD syndrome, Noonan-like syndrome), genomic sequence analysis panel, must include sequencing of at least 12 genes, including BRAF, CBL, HRAS, KRAS, MAP2K1, MAP2K2, NRAS, PTPN11, RAF1, RIT1, SHOC2 and SOS1	Prior authorization is required.		
81443	Genetic testing for severe inherited conditions (eg, cystic fibrosis, Ashkenazi Jewish-associated disorders [eg, Bloom syndrome, Canavan disease, Fanconi anemia type C, mucolipidosis type VI, Gaucher disease, Tay-Sachs disease], beta hemoglobinopathies, phenylketonuria, galactosemia), genomic sequence analysis panel, must include sequencing of at least 15 genes (eg, ACADM, ARSA, ASPA, ATP7B, BCKDHA, BCKDHB, BLM, CFTR, DHCR7, FANCC, G6PC, GAA, GALT, GBA, GBE1, HBB, HEXA, IKBKAP, MCOLN1, PAH)	Prior authorization is required.		
81445	Solid organ neoplasm, genomic sequence analysis panel, 5-50 genes, interrogation for sequence variants and copy number variants or rearrangements, if performed; DNA analysis or combined DNA and RNA analysis	Prior authorization is required.		
81448	Hereditary peripheral neuropathies (eg, Charcot-Marie-Tooth, spastic paraplegia), genomic sequence analysis panel, must include sequencing of at least 5 peripheral neuropathy-related genes (eg, BSCL2, GJB1, MFN2, MPZ, REEP1, SPAST, SPG11, SPTLC1)	Prior authorization is required.		
81450	Hematolymphoid neoplasm or disorder, genomic sequence analysis panel, 5-50 genes, interrogation for sequence variants, and copy number variants or rearrangements, or isoform expression or mRNA expression levels, if performed; DNA analysis or combined DNA and RNA analysis	Prior authorization is required.		
81455	Solid organ or hematolymphoid neoplasm or disorder, 51 or greater genes, genomic sequence analysis panel, interrogation for sequence variants and copy number variants or rearrangements, or isoform expression or mRNA expression levels, if performed; DNA analysis or combined DNA and RNA analysis	Prior authorization is required.		
81460	Whole mitochondrial genome (eg, Leigh syndrome, mitochondrial encephalomyopathy, lactic acidosis and stroke-like episodes [MELAS], myoclonic epilepsy with ragged-red fibers [MERFF], neuropathy, ataxia and retinitis pigmentosa [NARP], Leber hereditary optic neuropathy [LHON]), genomic sequence, must include sequence analysis of entire mitochondrial genome with heteroplasmy detection	Prior authorization is required.		
81465	Whole mitochondrial genome large deletion analysis panel (eg, Kearns-Sayre syndrome, chronic progressive external ophthalmoplegia), including heteroplasmy detection, if performed	Prior authorization is required.		

81470	X-linked intellectual disability (XLID) (eg, syndromic and non-syndromic XLID); genomic sequence analysis panel, must include sequencing of at least 60 genes, including ARX, ATRX, CDKL5, FGD1, FMR1, HUWE1, IL1RAPL, KDM5C, L1CAM, MECP2, MED12, MID1, OCRL, RPS6KA3 and SLC16A2	Prior authorization is required.		
81471	X-linked intellectual disability (XLID) (eg, syndromic and non-syndromic XLID); duplication/deletion gene analysis, must include analysis of at least 60 genes, including ARX, ATRX, CDKL5, FGD1, FMR1, HUWE1, IL1RAPL, KDM5C, L1CAM, MECP2, MED12, MID1, OCRL, RPS6KA3 and SLC16A2	Prior authorization is required.		
81479	Unlisted molecular pathology procedure	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1210 Oncologic Genetic Testing Panels and HHO-DE-MP-1250 BRCA1 & BRCA2 Genetic Mutation Testing and Related Genetic Counseling	
81490	Autoimmune (rheumatoid arthritis), analysis of 12 biomarkers using immunoassays, utilizing serum, prognostic algorithm reported as a disease activity score	Prior authorization is required.		
81493	Coronary artery disease, mRNA, gene expression profiling by real-time RT-PCR of 23 genes, utilizing whole peripheral blood, algorithm reported as a risk score	Prior authorization is required.		
81500	Oncology (ovarian), biochemical assays of two proteins (CA-125 and HE4), utilizing serum, with menopausal status, algorithm reported as a risk score	Prior authorization is required.		
81503	Oncology (ovarian), biochemical assays of five proteins (CA-125, apolipoprotein A1, beta-2 microglobulin, transferrin and pre-albumin), utilizing serum, algorithm reported as a risk score	Prior authorization is required.		
81504	Oncology (tissue of origin), microarray gene expression profiling of > 2000 genes, utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as tissue similarity scores	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1210 Oncologic Genetic Testing Panels	
81506	Endocrinology (type 2 diabetes), biochemical assays of seven analytes (glucose, HbA1c, insulin, hs-CRP, adiponectin, ferritin, interleukin 2-receptor alpha), utilizing serum or plasma, algorithm reporting a risk score	Prior authorization is required.		
81507	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	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1208 Fetal Aneuploidy Testing Using Noninvasive Cell-Free Fetal DNA	
81508	Fetal congenital abnormalities, biochemical assays of two proteins (PAPP-A, hCG [any form]), utilizing maternal serum, algorithm reported as a risk score	Prior authorization is required.		
81509	Fetal congenital abnormalities, biochemical assays of three proteins (PAPP-A, hCG [any form], DIA), utilizing maternal serum, algorithm reported as a risk score	Prior authorization is required.		
81510	Fetal congenital abnormalities, biochemical assays of three analytes (AFP, uE3, hCG [any form]), utilizing maternal serum, algorithm reported as a risk score	Prior authorization is required.		
81511	Fetal congenital abnormalities, biochemical assays of four analytes (AFP, uE3, hCG [any form], DIA) utilizing maternal serum, algorithm reported as a risk score (may include additional results from previous biochemical testing)	Prior authorization is required.		
81512	Fetal congenital abnormalities, biochemical assays of five analytes (AFP, uE3, total hCG, hyperglycosylated hCG, DIA) utilizing maternal serum, algorithm reported as a risk score	Prior authorization is required.		
81513	Infectious disease, bacterial vaginosis, quantitative real-time amplification of RNA markers for Atopobium vaginae, Gardnerella vaginalis and Lactobacillus species, utilizing vaginal-fluid specimens, algorithm reported as a positive or negative result for bacterial vaginosis	Prior authorization is required.		
81514	Infectious disease, bacterial vaginosis and vaginitis, quantitative real-time amplification of DNA markers for Gardnerella vaginalis, Atopobium vaginae, Megasphaera type 1, Bacterial Vaginosis Associated Bacteria-2 (BVAB-2) and Lactobacillus species (L. crispatus and L. jensenii), utilizing vaginal-fluid specimens, algorithm reported as a positive or negative for high likelihood of bacterial vaginosis, includes separate detection of Trichomonas vaginalis and/or Candida species (C. albicans, C. tropicalis, C. parapsilosis, C. dubliniensis), Candida glabrata, Candida krusei, when reported	Prior authorization is required.		
81518	Oncology (breast), mRNA, gene expression profiling by real-time RT-PCR of 11 genes (7 content and 4 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithms reported as percentage risk for metastatic recurrence and likelihood of benefit from extended endocrine therapy	Prior authorization is required.		
81519	Oncology (breast), mRNA, gene expression profiling by real-time RT-PCR of 21 genes, utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as recurrence score	Prior authorization is required.		
81520	Oncology (breast), mRNA gene expression profiling by hybrid capture of 58 genes (50 content and 8 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a recurrence risk score	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1210 Oncologic Genetic Testing Panels	
81521	Oncology (breast), mRNA, microarray gene expression profiling of 70 content genes and 465 housekeeping genes, utilizing fresh frozen or formalin-fixed paraffin-embedded tissue, algorithm reported as index related to risk of distant metastasis	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1210 Oncologic Genetic Testing Panels	
81522	Oncology (breast), mRNA, gene expression profiling by RT-PCR of 12 genes (8 content and 4 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as recurrence risk score	Prior authorization is required.		
81523	Oncology (breast), mRNA, next-generation sequencing gene expression profiling of 70 content genes and 31 housekeeping genes, utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as index related to risk to distant metastasis	Prior authorization is required.		
81525	Oncology (colon), mRNA, gene expression profiling by real-time RT-PCR of 12 genes (7 content and 5 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a recurrence score	Prior authorization is required.		

81528	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	Prior authorization is required for members under the age of 45. Reference policies for additional information.	HHO-DE-MP-1007 Colorectal Cancer Screening	
81529	Oncology (cutaneous melanoma), mRNA, gene expression profiling by real-time RT-PCR of 31 genes (28 content and 3 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as recurrence risk, including likelihood of sentinel lymph node metastasis	Prior authorization is required.		
81535	Oncology (gynecologic), live tumor cell culture and chemotherapeutic response by DAPI stain and morphology, predictive algorithm reported as a drug response score; first single drug or drug combination	Prior authorization is required.		
81536	Oncology (gynecologic), live tumor cell culture and chemotherapeutic response by DAPI stain and morphology, predictive algorithm reported as a drug response score; each additional single drug or drug combination (List separately in addition to code for primary procedure)	Prior authorization is required.		
81538	Oncology (lung), mass spectrometric 8-protein signature, including amyloid A, utilizing serum, prognostic and predictive algorithm reported as good versus poor overall survival	Prior authorization is required.		
81539	Oncology (high-grade prostate cancer), biochemical assay of four proteins (Total PSA, Free PSA, Intact PSA and human kallikrein-2 [hK2]), utilizing plasma or serum, prognostic algorithm reported as a probability score	Prior authorization is required.		
81540	Oncology (tumor of unknown origin), mRNA, gene expression profiling by real-time RT-PCR of 92 genes (87 content and 5 housekeeping) to classify tumor into main cancer type and subtype, utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a probability of a predicted main cancer type and subtype	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1210 Oncologic Genetic Testing Panels	
81541	Oncology (prostate), mRNA gene expression profiling by real-time RT-PCR of 46 genes (31 content and 15 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a disease-specific mortality risk score	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1210 Oncologic Genetic Testing Panels	
81542	Oncology (prostate), mRNA, microarray gene expression profiling of 22 content genes, utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as metastasis risk score	Prior authorization is required.		
81546	Oncology (thyroid), mRNA, gene expression analysis of 10,196 genes, utilizing fine needle aspirate, algorithm reported as a categorical result (eg, benign or suspicious)	Prior authorization is required.		
81551	Oncology (prostate), promoter methylation profiling by real-time PCR of 3 genes (GSTP1, APC, RASSF1), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a likelihood of prostate cancer detection on repeat biopsy	Prior authorization is required.		
81552	Oncology (uveal melanoma), mRNA, gene expression profiling by real-time RT-PCR of 15 genes (12 content and 3 housekeeping), utilizing fine needle aspirate or formalin-fixed paraffin-embedded tissue, algorithm reported as risk of metastasis	Prior authorization is required.		
81554	Pulmonary disease (idiopathic pulmonary fibrosis [IPF]), mRNA, gene expression analysis of 190 genes, utilizing transbronchial biopsies, diagnostic algorithm reported as categorical result (eg, positive or negative for high probability of usual interstitial pneumonia [UIP])	Prior authorization is required.		
81595	Cardiology (heart transplant), mRNA, gene expression profiling by real-time quantitative PCR of 20 genes (11 content and 9 housekeeping), utilizing subfraction of peripheral blood, algorithm reported as a rejection risk score	Prior authorization is required.		
81596	Infectious disease, chronic hepatitis C virus (HCV) infection, six biochemical assays (ALT, A2-macroglobulin, apolipoprotein A-1, total bilirubin, GGT and haptoglobin) utilizing serum, prognostic algorithm reported as scores for fibrosis and necroinflammatory activity in liver	Prior authorization is required.		
81599	Unlisted multianalyte assay with algotithmic analysis procedure	Prior authorization is required.		
82270	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)	Prior authorization is required for members under the age of 45. Reference policies for additional information.	HHO-DE-MP-1007 Colorectal Cancer Screening	
82272	Blood, occult, by peroxidase activity (eg, guaiac), qualitative, feces, 1-3 simultaneous determinations, performed for other than colorectal neoplasm screening	Prior authorization is required for members under the age of 45. Reference policies for additional information.	HHO-DE-MP-1007 Colorectal Cancer Screening	
82274	Blood, occult, by fecal hemoglobin determination by immunoassay, qualitative, feces, 1-3 simultaneous determinations	Prior authorization is required for members under the age of 45. Reference policies for additional information.	HHO-DE-MP-1007 Colorectal Cancer Screening	
82523	Collagen cross links, any method	Prior authorization is required.		
82607	Cyanocobalamin (Vitamin B-12);	Prior authorization is required.		
82608	Cyanocobalamin (Vitamin B-12); unsaturated binding capacity	Prior authorization is required.		
82955	Glucose-6-phosphate dehydrogenase (G6PD); quantitative	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1002 Pharmacogenomic Testing	
83090	Homocysteine	Prior authorization is required.		
83937	Osteocalcin (bone g1a protein)	Prior authorization is required.		
84080	Phosphatase, alkaline; isoenzymes	Prior authorization is required.		
84431	Thromboxane metabolite(s), including thromboxane if performed, urine	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1002 Pharmacogenomic Testing	
84591	Pathology test	Prior authorization is required.		
84999	Unlisted chemistry procedure	Prior authorization is required for not otherwise classified codes.		
85999	Unlisted hematology procedure	Prior authorization is required.		
86849	Unlisted immunology procedure	Prior authorization is required.		
86999	Unlisted transfusion medicine procedure	Prior authorization is required for not otherwise classified codes.		
87299	Immunoassay	Prior authorization is required.		
87450	Immunoassay	Prior authorization is required.		

87899	Infectious agent antigen detection by immunoassay with direct optical (ie, visual) observation; not otherwise specified	Prior authorization is required.		
87999	Unlisted microbiology procedure	Prior authorization is required for not otherwise classified codes.		
88160	Cytopathology, smears, any other source; screening and interpretation	Prior authorization is required for members under the age of 45. Reference policies for additional information.	HHO-DE-MP-1007 Colorectal Cancer Screening	
88199	Cytopathology	Prior authorization is required.		
88299	Unlisted cytogenetic study	Prior authorization is required. Reference policies for additional information. Prior authorization is required for not otherwise classified codes.	HHO-DE-MP-1210 Oncologic Genetic Testing Panels	
88360	Morphometric analysis, tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, per specimen, each single antibody stain procedure; manual	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1002 Pharmacogenomic Testing and HHO-DE-MP-1028 Molecular Tumor Markers for Non-Small Lung Cancer	
88361	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	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1028 Molecular Tumor Markers for Non-Small Lung Cancer	
88399	Surgical pathology procedure	Prior authorization is required.		
88749	Pathology test	Prior authorization is required.		
89240	Unlisted pathology	Prior authorization is required.		
89398	Reproductive laboratory procedure	Prior authorization is required.		
90378	Respiratory syncytial virus, monoclonal antibody, recombinant, for IM use, 50 mg, each	Prior authorization is required.		
90399	Unlisted immune globulin	Prior authorization is required.		
90749	Unlisted vaccine	Prior authorization is required.		
90867	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; initial, including cortical mapping, motor threshold determination, delivery and management	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1147 Transcranial Magnetic Stimulation (TMS)	
90868	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent delivery and management, per session	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1147 Transcranial Magnetic Stimulation (TMS)	
90869	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent motor threshold re-determination with delivery and management	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1147 Transcranial Magnetic Stimulation (TMS)	
90870	Electroconvulsive therapy (includes necessary monitoring)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1162 Electroconvulsive Therapy	
90899	Unlisted psychiatric service or procedure	Prior authorization is required.		
90912	Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry, when performed; initial 15 minutes of one-on-one physician or other qualified health care professional contact with the patient	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1193 Biofeedback and HHO-DE-MP-1117 Urinary Incontinence Therapy	
90913	Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry, when performed; each additional 15 minutes of one-on-one physician or other qualified health care professional contact with the patient (List separately in addition to code for primary procedure)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1193 Biofeedback and HHO-DE-MP-1117 Urinary Incontinence Therapy	
91034	Esophagus, gastroesophageal reflux test; with nasal catheter pH electrode(s) placement, recording, analysis and interpretation	Prior authorization is required.		
91035	Esophagus, gastroesophageal reflux test; with mucosal attached telemetry pH electrode placement, recording, analysis and interpretation	Prior authorization is required.		
91110	Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus through ileum, with interpretation and report	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1005 Wireless Capsule Endoscopy as a Diagnostic Technique in Disorders of the Small Bowel, Esophagus and Colon	
91111	Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus with interpretation and report	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1005 Wireless Capsule Endoscopy as a Diagnostic Technique in Disorders of the Small Bowel, Esophagus and Colon	
91113	Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), colon, with interpretation and report	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1005 Wireless Capsule Endoscopy as a Diagnostic Technique in Disorders of the Small Bowel, Esophagus and Colon	
91200	Liver elastography, mechanically induced shear wave (eg, vibration), without imaging, with interpretation and report	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1014 Noninvasive Assessment of Liver Fibrosis in Chronic Hepatitis	
91299	Unlisted diagnostic gastroenterology procedure	Prior authorization is required for not otherwise classified codes. Reference policies for additional information.	HHO-DE-MP-1005 Wireless Capsule Endoscopy as a Diagnostic Technique in Disorders of the Small Bowel, Esophagus and Colon	
92002	Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate	Coverage is managed by Davis Vision		
92004	Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive	Coverage is managed by Davis Vision		
92012	Ophthalmological services: medical examination and evaluation	Coverage is managed by Davis Vision		
92014	Ophthalmological services: medical examination and evaluation	Coverage is managed by Davis Vision		
92065	Orthoptic training; performed by a physician or other qualified health care professional	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1228 Vision Therapy	
92499	Unlisted ophthalmological service or procedure	Prior authorization is required.		
92507	Treatment of speech, language, voice, communication and/or auditory processing disorder; individual	Prior authorization is required. Reference policies for additional information.	HHO-DE-RP-1013 Therapy Services	
92508	Treatment Of Speech, Language, Voice, Communication and/or Auditory Processing Disorder, Group, 2 Or More Individuals	Prior authorization is required. Reference policies for additional information.	HHO-DE-RP-1013 Therapy Services	
92512	Nasal Function Studies,Eg, Rhinomanometry	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1179 Rhinomanometry	
92521	Evaluation of speech fluency (eg, stuttering, cluttering)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1145 Cochlear Implants and HHO-DE-RP-1013 Therapy Services	

92522	Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria);	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1145 Cochlear Implants and HHO-DE-RP-1013 Therapy Services	
92523	Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (eg, receptive and expressive language)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1145 Cochlear Implants and HHO-DE-RP-1013 Therapy Services	
92524	Behavioral and qualitative analysis of voice and resonance	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1145 Cochlear Implants and HHO-DE-RP-1013 Therapy Services	
92526	Treatment Of Swallowing Dysfunction And/or Oral Function For Feeding	Prior authorization is required. Reference policies for additional information.	HHO-DE-RP-1013 Therapy Services	
92550	Tympanometry and reflex threshold measurements	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1190 External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing	
92601	Diagnostic analysis of cochlear implant, patient younger than 7 years of age; with programming	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1145 Cochlear Implants	
92602	Diagnostic analysis of cochlear implant, patient younger than 7 years of age; subsequent reprogramming	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1145 Cochlear Implants	
92603	Diagnostic analysis of cochlear implant, age 7 years or older; with programming	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1145 Cochlear Implants	
92604	Diagnostic analysis of cochlear implant, age 7 years or older; subsequent reprogramming	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1145 Cochlear Implants	
92605	Evaluation For Prescription Of Non-speech-generating Augmentative And Alternative Communication Device, Face-to-face With The Patient; First Hour	Prior authorization is required. Reference policies for additional information.	HHO-DE-RP-1013 Therapy Services	
92606	Therapeutic Service(s) For The Use Of Non-speech-generating Device, Including Programming And Modification	Prior authorization is required. Reference policies for additional information.	HHO-DE-RP-1013 Therapy Services	
92607	Evaluation For Prescription For Non-speech-generating Augmentative And Alternative Communication Device, Face-to-face With The Patient; First Hour	Prior authorization is required. Reference policies for additional information.	HHO-DE-RP-1013 Therapy Services	
92608	Evaluation For Prescription For Non-speech-generating Augmentative And Alternative Communication Device, Face-to-face With The Patient; Each Additional 30 Minutes	Prior authorization is required. Reference policies for additional information.	HHO-DE-RP-1013 Therapy Services	
92609	Therapeutic Service(s) For Use Of Speech-generating Device, Including Programming And Modification	Prior authorization is required. Reference policies for additional information.	HHO-DE-RP-1013 Therapy Services	
92610	Evaluation Of Oral And Pharyngeal Swallowing Function	Prior authorization is required. Reference policies for additional information.	HHO-DE-RP-1013 Therapy Services	
92611	Motion Fluoroscopic Evaluation Of Swallowing Function By Cine Or Video Recording	Prior authorization is required. Reference policies for additional information.	HHO-DE-RP-1013 Therapy Services	
92627	Evaluation Of Auditory Function For Surgically Implanted Device(s) Candidacy Or Postoperative Status Of A Surgically Implanted Device(s); Each Additional 15 Minutes(list Separately In Addition To Code For Primary Procedure)	Prior authorization is required. Reference policies for additional information.	HHO-DE-RP-1013 Therapy Services	
92700	Unlisted otorhinolaryngological service or procedure	Prior authorization is required for not otherwise classified codes.		
92997	Percutaneous transluminal pulmonary artery balloon angioplasty; single vessel	Prior authorization is required.		
92998	Percutaneous transluminal pulmonary artery balloon angioplasty; each additional vessel (List separately in addition to code for primary procedure)	Prior authorization is required.		
93243	External electrocardiographic recording for more than 48 hours up to 7 days by continuous rhythm recording and storage; scanning analysis with report	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1152 Cardiac Monitors	
93261	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	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1152 Cardiac Monitors	
93264	Remote monitoring of a wireless pulmonary artery pressure sensor for up to 30 days, including at least weekly downloads of pulmonary artery pressure recordings, interpretation(s), trend analysis and report(s) by a physician or other qualified health care professional	Prior authorization is required. Reference policies for additional information. Prior authorization is required for not otherwise classified codes.	HHO-DE-MP-1142 Implantable Pulmonary Artery Pressure Measurement Device	
93292	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	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1138 Wearable Cardioverter-Defibrillatand	
93303	Transthoracic echocardiography for congenital cardiac anomalies; complete	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
93304	Transthoracic echocardiography for congenital cardiac anomalies; follow-up or limited study	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.

93306	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	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
93307	Echocardiography, transthoracic, real-time with image documentation (2d) with or without m-mode recording; complete	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
93308	Echocardiography, transthoracic, real-time with image documentation (2d) with or without m-mode recording; follow-up or limited study	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
93312	TEE 2D;Incl Probe Placement, Imaging/Interp/Report	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
93313	Echocardiography, transesophageal, real-time with image documentation (2D) (with or without M-mode recording); placement of transesophageal probe only	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
93314	Echocardiography, transesophageal, real-time with image documentation (2D) (with or without M-mode recording); image acquisition, interpretation and report only	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
93315	Transesophageal echocardiography for congenital cardiac anomalies; including probe placement, image acquisition, interpretation and report	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
93316	Transesophageal echocardiography for congenital cardiac anomalies; placement of transesophageal probe only	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
93317	Transesophageal echocardiography for congenital cardiac anomalies; image acquisition, interpretation and report only	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
93319	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	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
93320	Doppler echocardiography, pulsed wave and/or continuous wave with spectral display; complete	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
93321	Doppler echocardiography, pulsed wave and/or continuous wave with spectral display; follow-up or limited study	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
93325	Doppler echocardiography color flow velocity mapping	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
93350	Echocardiography, transthoracic, real-time with image documentation (2d), with or without m-mode recording, during rest and cardiovascular stress test, with interpretation and report	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
93351	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	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
93356	Myocardial strain imaging using speckle tracking-derived assessment of myocardial mechanics (List separately in addition to codes for echocardiography imaging)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
93451	Right Heart Catheterization Including Measurement(S) Of Oxygen Saturation And Cardiac Output, When Performed	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
93452	Left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed	Prior authorization is required.		
93453	Combined right and left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
93454	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
93455	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	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
93456	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right heart catheterization	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
93457	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	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
93458	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	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
93459	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	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.

93460	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	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
93461	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	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
93462	Left heart catheterization by transseptal puncture through intact septum or by transapical puncture (list separately in addition to code for primary procedure)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
93580	Percutaneous transcatheter closure of congenital interatrial communication (ie, Fontan fenestration, atrial septal defect) with implant	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1234 Transcatheter Closure Devices for Septal Defects	
93581	Percutaneous transcatheter closure of a congenital ventricular septal defect with implant	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1234 Transcatheter Closure Devices for Septal Defects	
93582	Percutaneous transcatheter closure of patent ductus arteriosus	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1234 Transcatheter Closure Devices for Septal Defects	
93590	Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, mitral valve	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1126 Transcatheter Mitral Valve Repair/Replacement	
93591	Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, aortic valve	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1125 Transcatheter Aortic Valve Replacement	
93592	Percutaneous transcatheter closure of paravalvular leak; each additional occlusion device (List separately in addition to code for primary procedure)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1126 Transcatheter Mitral Valve Repair/Replacement	
93593	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	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
93594	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	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
93595	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	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
93596	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	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
93597	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	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
93613	Intracardiac electrophysiologic 3-dimensional mapping (List separately in addition to code for primary procedure)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1187 Cardiac Ablation Procedure	
93650	Intracardiac catheter ablation of atrioventricular node function, atrioventricular conduction for creation of complete heart block, with or without temporary pacemaker placement	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1187 Cardiac Ablation Procedure	
93653	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	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1187 Cardiac Ablation Procedure	
93654	Comprehensive electrophysiologic evaluation with insertion and repositioning of multiple electrode catheters, induction or attempted induction of an arrhythmia with right atrial pacing and recording and catheter ablation of 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	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1187 Cardiac Ablation Procedure	
93655	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)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1187 Cardiac Ablation Procedure	
93656	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	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1187 Cardiac Ablation Procedure	
93657	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)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1187 Cardiac Ablation Procedure	

93662	Intracardiac echocardiography during therapeutic/diagnostic intervention, including imaging supervision and interpretation (List separately in addition to code for primary procedure)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1187 Cardiac Ablation Procedure	
93668	Peripheral arterial disease (PAD) rehabilitation, per session	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1013 Supervised Exercise Therapy for Peripheral Artery Disease	
93745	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	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1138 Wearable Cardioverter-Defibrillatand	
93750	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	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1104 Artificial Hearts and Ventricular Assist Devices	
93784	Ambulatory blood pressure monitoring, utilizing report-generating software, automated, worn continuously for 24 hours or longer; including recording, scanning analysis, interpretation and report	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1032 Ambulatory Blood Pressure Monitors	
93786	Ambulatory blood pressure monitoring, utilizing report-generating software, automated, worn continuously for 24 hours or longer; recording only	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1032 Ambulatory Blood Pressure Monitors	
93788	Ambulatory blood pressure monitoring, utilizing report-generating software, automated, worn continuously for 24 hours or longer; scanning analysis with report	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1032 Ambulatory Blood Pressure Monitors	
93790	Ambulatory blood pressure monitoring, utilizing report-generating software, automated, worn continuously for 24 hours or longer; review with interpretation and report	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1032 Ambulatory Blood Pressure Monitors	
93797	Physician or other qualified health care professional services for outpatient cardiac rehabilitation without continuous ECG monitoring (per session)	Prior authorization is required. Reference policies for additional information.	HHO-DE-RP-1013 Therapy Services	
93798	Physician or other qualified health care professional services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1026 Cardiac Rehab and HHO-DE-RP-1013 Therapy Services	
93799	Unlisted cardiovascular service or procedure	Prior authorization is required. Reference policies for additional information. Prior authorization is required for not otherwise classified codes.	HHO-DE-MP-1142 Implantable Pulmonary Artery Pressure Measurement Device	
93998	Noninvasive vascular procedure	Prior authorization is required.		
94625	Physician or other qualified health care professional services for outpatient pulmonary rehabilitation; without continuous oximetry monitoring (per session)	Prior authorization is required. Reference policies for additional information.	HHO-DE-RP-1013 Therapy Services	
94626	Physician or other qualified health care professional services for outpatient pulmonary rehabilitation; with continuous oximetry monitoring (per session)	Prior authorization is required. Reference policies for additional information.	HHO-DE-RP-1013 Therapy Services	
94680	Oxygen Uptake, Expired Gas Analysis; Rest And Exercise, Direct, Simple	Prior authorization is required. Reference policies for additional information.	HHO-DE-RP-1013 Therapy Services	
94772	Circadian respiratory pattern recording (pediatric pneumogram), 12-24 hour continuous recording, infant	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1064 Diagnosis and Treatment of Obstructive Sleep Apnea in Adults and HHO-DE-MP-1065 Diagnosis and Treatment of Obstructive Sleep Apnea in Pediatric Individuals	
94799	Pulmonary service	Prior authorization is required.		
95199	Allergy immunology	Prior authorization is required.		
95700	Electroencephalogram (EEG) continuous recording, with video when performed, setup, patient education and takedown when performed, administered in person by EEG technologist, minimum of 8 channels	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1009 Deep Brain Stimulation and HHO-DE-MP-1088 Electroencephalogram (EEG) Technologies	
95705	Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, 2-12 hours; unmonitored	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1009 Deep Brain Stimulation and HHO-DE-MP-1088 Electroencephalogram (EEG) Technologies	
95706	Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, 2-12 hours; with intermittent monitoring and maintenance	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1009 Deep Brain Stimulation and HHO-DE-MP-1088 Electroencephalogram (EEG) Technologies	
95707	Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, 2-12 hours; with continuous, real-time monitoring and maintenance	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1009 Deep Brain Stimulation and HHO-DE-MP-1088 Electroencephalogram (EEG) Technologies	
95708	Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, each increment of 12-26 hours; unmonitored	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1009 Deep Brain Stimulation and HHO-DE-MP-1088 Electroencephalogram (EEG) Technologies	
95709	Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, each increment of 12-26 hours; with intermittent monitoring and maintenance	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1009 Deep Brain Stimulation and HHO-DE-MP-1088 Electroencephalogram (EEG) Technologies	
95710	Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, each increment of 12-26 hours; with continuous, real-time monitoring and maintenance	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1009 Deep Brain Stimulation and HHO-DE-MP-1088 Electroencephalogram (EEG) Technologies	
95711	Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, 2-12 hours; unmonitored	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1009 Deep Brain Stimulation and HHO-DE-MP-1088 Electroencephalogram (EEG) Technologies	
95712	Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, 2-12 hours; with intermittent monitoring and maintenance	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1009 Deep Brain Stimulation and HHO-DE-MP-1088 Electroencephalogram (EEG) Technologies	
95713	Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, 2-12 hours; with continuous, real-time monitoring and maintenance	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1009 Deep Brain Stimulation and HHO-DE-MP-1088 Electroencephalogram (EEG) Technologies	
95714	Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, each increment of 12-26 hours; unmonitored	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1009 Deep Brain Stimulation and HHO-DE-MP-1088 Electroencephalogram (EEG) Technologies	
95715	Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, each increment of 12-26 hours; with intermittent monitoring and maintenance	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1009 Deep Brain Stimulation and HHO-DE-MP-1088 Electroencephalogram (EEG) Technologies	
95716	Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, each increment of 12-26 hours; with continuous, real-time monitoring and maintenance	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1009 Deep Brain Stimulation and HHO-DE-MP-1088 Electroencephalogram (EEG) Technologies	

95717	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation and report, 2-12 hours of EEG recording; without video	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1009 Deep Brain Stimulation and HHO-DE-MP-1088 Electroencephalogram (EEG) Technologies	
95718	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation and report, 2-12 hours of EEG recording; with video (VEEG)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1009 Deep Brain Stimulation and HHO-DE-MP-1088 Electroencephalogram (EEG) Technologies	
95719	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, each increment of greater than 12 hours, up to 26 hours of EEG recording, interpretation and report after each 24-hour period; without video	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1009 Deep Brain Stimulation and HHO-DE-MP-1088 Electroencephalogram (EEG) Technologies	
95720	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, each increment of greater than 12 hours, up to 26 hours of EEG recording, interpretation and report after each 24-hour period; with video (VEEG)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1009 Deep Brain Stimulation and HHO-DE-MP-1088 Electroencephalogram (EEG) Technologies	
95721	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation and summary report, complete study; greater than 36 hours, up to 60 hours of EEG recording, without video	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1009 Deep Brain Stimulation and HHO-DE-MP-1088 Electroencephalogram (EEG) Technologies	
95722	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation and summary report, complete study; greater than 36 hours, up to 60 hours of EEG recording, with video (VEEG)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1009 Deep Brain Stimulation and HHO-DE-MP-1088 Electroencephalogram (EEG) Technologies	
95723	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation and summary report, complete study; greater than 60 hours, up to 84 hours of EEG recording, without video	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1009 Deep Brain Stimulation and HHO-DE-MP-1088 Electroencephalogram (EEG) Technologies	
95724	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation and summary report, complete study; greater than 60 hours, up to 84 hours of EEG recording, with video (VEEG)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1009 Deep Brain Stimulation and HHO-DE-MP-1088 Electroencephalogram (EEG) Technologies	
95725	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation and summary report, complete study; greater than 84 hours of EEG recording, without video	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1009 Deep Brain Stimulation and HHO-DE-MP-1088 Electroencephalogram (EEG) Technologies	
95726	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation and summary report, complete study; greater than 84 hours of EEG recording, with video (VEEG)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1009 Deep Brain Stimulation and HHO-DE-MP-1088 Electroencephalogram (EEG) Technologies	
95782	Polysomnography; younger than 6 years, sleep staging with 4 or more additional parameters of sleep, attended by a technologist	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1064 Diagnosis and Treatment of Obstructive Sleep Apnea in Adults and HHO-DE-MP-1065 Diagnosis and Treatment of Obstructive Sleep Apnea in Pediatric Individuals	
95783	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	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1064 Diagnosis and Treatment of Obstructive Sleep Apnea in Adults and HHO-DE-MP-1065 Diagnosis and Treatment of Obstructive Sleep Apnea in Pediatric Individuals	
95805	Multiple sleep latency or maintenance of wakefulness testing, recording, analysis and interpretation of physiological measurements of sleep during multiple trials to assess sleepiness	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1064 Diagnosis and Treatment of Obstructive Sleep Apnea in Adults and HHO-DE-MP-1065 Diagnosis and Treatment of Obstructive Sleep Apnea in Pediatric Individuals	
95806	Sleep study, unattended, simultaneous recording of, heart rate, oxygen saturation, respiratory airflow and respiratory effort (eg, thoracoabdominal movement)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1064 Diagnosis and Treatment of Obstructive Sleep Apnea in Adults and HHO-DE-MP-1065 Diagnosis and Treatment of Obstructive Sleep Apnea in Pediatric Individuals	
95807	Sleep study, simultaneous recording of ventilation, respiratory effort, ECG or heart rate and oxygen saturation, attended by a technologist	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1064 Diagnosis and Treatment of Obstructive Sleep Apnea in Adults and HHO-DE-MP-1065 Diagnosis and Treatment of Obstructive Sleep Apnea in Pediatric Individuals	
95808	Polysomnography; any age, sleep staging with 1-3 additional parameters of sleep, attended by a technologist	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1064 Diagnosis and Treatment of Obstructive Sleep Apnea in Adults and HHO-DE-MP-1065 Diagnosis and Treatment of Obstructive Sleep Apnea in Pediatric Individuals	
95810	Polysomnography; age 6 years or older, sleep staging with 4 or more additional parameters of sleep, attended by a technologist	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1064 Diagnosis and Treatment of Obstructive Sleep Apnea in Adults and HHO-DE-MP-1065 Diagnosis and Treatment of Obstructive Sleep Apnea in Pediatric Individuals	
95811	Polysomnography; age 6 years or older, sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bilevel ventilation, attended by a technologist	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1064 Diagnosis and Treatment of Obstructive Sleep Apnea in Adults and HHO-DE-MP-1065 Diagnosis and Treatment of Obstructive Sleep Apnea in Pediatric Individuals	

95812	Electroencephalogram (EEG) extended monitoring; 41-60 minutes	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1009 Deep Brain Stimulation and HHO-DE-MP-1088 Electroencephalogram (EEG) Technologies	
95813	Electroencephalogram (EEG) extended monitoring; 61-119 minutes	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1009 Deep Brain Stimulation and HHO-DE-MP-1088 Electroencephalogram (EEG) Technologies	
95819	Electroencephalogram (EEG); including recording awake and asleep	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1009 Deep Brain Stimulation and HHO-DE-MP-1088 Electroencephalogram (EEG) Technologies	
95824	Electroencephalogram (EEG); cerebral death evaluation only	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1009 Deep Brain Stimulation and HHO-DE-MP-1088 Electroencephalogram (EEG) Technologies	
95836	Electrocorticogram from an implanted brain neurostimulator pulse generator/transmitter, including recording, with interpretation and written report, up to 30 days	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1009 Deep Brain Stimulation	
95867	Needle electromyography; cranial nerve supplied muscle(s), unilateral	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1136 Temporomandibular Joint Dysfunction	
95868	Needle electromyography; cranial nerve supplied muscles, bilateral	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1136 Temporomandibular Joint Dysfunction	
95925	Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper limbs	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1136 Temporomandibular Joint Dysfunction	
95937	Neuromuscular junction testing (repetitive stimulation, paired stimuli), each nerve, any 1 method	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1136 Temporomandibular Joint Dysfunction	
95961	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	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1009 Deep Brain Stimulation and HHO-DE-MP-1088 Electroencephalogram (EEG) Technologies	
95962	Functional cortical and subcortical mapping by stimulation and/or recording of electrodes on brain surface, or of depth electrodes, to provoke seizures or identify vital brain structures; each additional hour of attendance by a physician or other qualified health care professional (List separately in addition to code for primary procedure)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1009 Deep Brain Stimulation and HHO-DE-MP-1088 Electroencephalogram (EEG) Technologies	
95970	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	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1009 Deep Brain Stimulation and HHO-DE-MP-1131 Responsive Neurostimulation for the Treatment of Refractory Partial Epilepsy	
95976	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	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1009 Deep Brain Stimulation and HHO-DE-MP-1131 Responsive Neurostimulation for the Treatment of Refractory Partial Epilepsy	
95977	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	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1009 Deep Brain Stimulation and HHO-DE-MP-1131 Responsive Neurostimulation for the Treatment of Refractory Partial Epilepsy	
95980	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; intraoperative, with programming	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1235 Gastric Electrical Stimulation and Gastric Pacing	
95981	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; subsequent, without reprogramming	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1235 Gastric Electrical Stimulation and Gastric Pacing	
95982	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	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1235 Gastric Electrical Stimulation and Gastric Pacing	
95983	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	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1009 Deep Brain Stimulation and HHO-DE-MP-1131 Responsive Neurostimulation for the Treatment of Refractory Partial Epilepsy	
95984	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)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1009 Deep Brain Stimulation and HHO-DE-MP-1131 Responsive Neurostimulation for the Treatment of Refractory Partial Epilepsy	

95999	Unlisted neurological or neuromuscular diagnostic procedure	Prior authorization is required. Reference policies for additional information. Prior authorization is required for not otherwise classified codes.	HHO-DE-MP-1074 Concussion Testing	
96001	Comprehensive Computer-based Motion Analysis By Video-taping And 3-d Kinematics; With Dynamic Plantar Pressure Measurements During Walking	Prior authorization is required. Reference policies for additional information.	HHO-DE-RP-1013 Therapy Services	
96002	Dynamic Surface Electromyography, During Walking Or Other Functional Activities, 1-12 Muscles	Prior authorization is required. Reference policies for additional information.	HHO-DE-RP-1013 Therapy Services	
96004	Review And Interpretation By Physician Or Other Qualified Health Care Professional Of Comprehensive Computer-based Motion Analysis, Dynamic Plantar Pressure Measurements, Dynamic Surface Electromyography During Walking Or Other Functional Activities and Dynamic Fine Wire	Prior authorization is required. Reference policies for additional information.	HHO-DE-RP-1013 Therapy Services	
96112	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	Prior authorization is required.		
96116	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [eg, acquired knowledge, attention, language, memory, planning and problem solving and visual spatial abilities]), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; first hour	Prior authorization is required.		
96121	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [eg, acquired knowledge, attention, language, memory, planning and problem solving and visual spatial abilities]), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; each additional hour (List separately in addition to code for primary procedure)	Prior authorization is required.		
96125	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	Prior authorization is required.		
96130	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	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1074 Concussion Testing and HHO-DE-MP-1045 Autism Spectrum Disorders	
96131	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)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1074 Concussion Testing and HHO-DE-MP-1045 Autism Spectrum Disorders	
96132	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	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1074 Concussion Testing and HHO-DE-MP-1045 Autism Spectrum Disorders	
96133	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)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1074 Concussion Testing and HHO-DE-MP-1045 Autism Spectrum Disorders	
96136	Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; first 30 minutes	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1074 Concussion Testing and HHO-DE-MP-1045 Autism Spectrum Disorders	
96137	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)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1074 Concussion Testing and HHO-DE-MP-1045 Autism Spectrum Disorders	
96138	Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; first 30 minutes	Prior authorization is required.		
96139	Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; each additional 30 minutes (List separately in addition to code for primary procedure)	Prior authorization is required.		
96146	Psychological or neuropsychological test administration, with single automated, standardized instrument via electronic platform, with automated result only	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1074 Concussion Testing and HHO-DE-MP-1045 Autism Spectrum Disorders	
96379	Unlisted injectable/therapeutic	Prior authorization is required.		
96416	Chemotherapy administration, intravenous infusion technique; initiation of prolonged chemotherapy infusion (more than 8 hours), requiring use of a portable or implantable pump	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1134 Portable External Infusion Pump	
96425	Chemotherapy administration, intra-arterial; infusion technique, initiation of prolonged infusion (more than 8 hours), requiring the use of a portable or implantable pump	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1134 Portable External Infusion Pump	
96521	Refilling and maintenance of portable pump	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1134 Portable External Infusion Pump	
96549	Unlisted chemotherapeutic injectable procedure	Prior authorization is required.		
96567	Photodynamic therapy by external application of light to destroy premalignant lesions of the skin and adjacent mucosa with application and illumination/activation of photosensitive drug(s), per day	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1034 Treatment of Malignant Skin Lesions	

96573	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	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1034 Treatment of Malignant Skin Lesions	
96574	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	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1034 Treatment of Malignant Skin Lesions	
96999	Unlisted special dermatological service or procedure	Prior authorization is required.		
97032	Application of a modality to 1 or more areas; electrical stimulation (manual), each 15 minutes	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1117 Urinary Incontinence Therapy	
97033	Application of a modality to 1 or more areas; iontophoresis, each 15 minutes	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1136 Temporomandibular Joint Dysfunction and HHO-DE-MP-1137 Hyperhidrosis	
97039	Unlisted physical medicine	Prior authorization is required.		
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility.	Prior authorization is required. Reference policies for additional information.	HHO-DE-RP-1013 Therapy Services	
97113	Therapeutic Procedure, 1 Or More Areas, Each 15 Minutes; Aquatic Therapy With Therapeutic Exercises	Prior authorization is required. Reference policies for additional information.	HHO-DE-RP-1013 Therapy Services	
97124	Therapeutic procedure, 1 or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1136 Temporomandibular Joint Dysfunction	
97129	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	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1044 Cognitive Rehabilitation	
97130	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)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1044 Cognitive Rehabilitation	
97139	Unlisted physical medicine	Prior authorization is required.		
97140	Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1136 Temporomandibular Joint Dysfunction	
97151	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	Prior authorization is required.		
97530	Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1117 Urinary Incontinence Therapy and HHO-DE-RP-1013 Therapy Services	
97605	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	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1039 Negative Pressure Wound Therapy	
97606	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	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1039 Negative Pressure Wound Therapy	
97750	Physical Performance Test Or Measurement (eg, Musculoskelteal, Functional Capacity), With Written Report, Each 15 Minutes	Prior authorization is required. Reference policies for additional information.	HHO-DE-RP-1013 Therapy Services	
97760	Orthotic (s) Management And Training (including Assessment And Fitting When Not Otherwise Reported), Upper Extremity(ies), Lower Extremity(ies) And/or Trunk, Initial Orthotic(s) Encounter , Each 15 Minutes	Prior authorization is required. Reference policies for additional information.	HHO-DE-RP-1013 Therapy Services	
97761	Prosthetic(s) Training, Upper And/or Lower Extremity(ies), Initial Prosthetic (s) Encounter , Each 15 Minutes	Prior authorization is required. Reference policies for additional information.	HHO-DE-RP-1013 Therapy Services	
97763	Orthotic(s)/prosthetic(s) Management And/or Training, Upper Extremity(ies), Lower Extremity(ies) and/or Trunk, Subsequent Orthotic(s) Encounter, Each 15 Minutes	Prior authorization is required. Reference policies for additional information.	HHO-DE-RP-1013 Therapy Services	
97799	Unlisted physical medicine/rehabilitation service or procedure	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1136 Temporomandibular Joint Dysfunction	
98940	Chiropractic manipulative treatment (CMT); spinal, 1-2 regions	Prior authorization is required for members under age 13. Prior authorization is required for members age 13 and older after the first 26 manipulations. Reference policies for additional information.	HHO-DE-RP-1120 Chiropractic Benefits and Services	
98941	Chiropractic manipulative treatment (CMT); spinal, 3-4 regions	Prior authorization is required for members under age 13. Prior authorization is required for members age 13 and older after the first 26 manipulations. Reference policies for additional information.	HHO-DE-RP-1120 Chiropractic Benefits and Services	
98942	Chiropractic manipulative treatment (CMT); spinal, 5 regions	Prior authorization is required for members under age 13. Prior authorization is required for members age 13 and older after the first 26 manipulations. Reference policies for additional information.	HHO-DE-RP-1120 Chiropractic Benefits and Services	

98943	Chiropractic manipulative treatment (CMT); extraspinal, 1 or more regions	Prior authorization is required for members under age 13. Prior authorization is required for members age 13 and older after the first 26 manipulations. Reference policies for additional information.	HHO-DE-RP-1120 Chiropractic Benefits and Services	
99091	Collection And Interpretation Of Physiologic Data (eg, Ecg, Blood Pressure, Glucose Monitoring), Digitally Stored And/or Transmitted By The Patient And/or Caregiver To The Physician Or Other Qualified Healthcare Professional, Requiring A Minimum Of 30 Minutes Of Time	Prior authorization is required. Reference policies for additional information.	HHO-DE-RP-1013 Therapy Services	
99183	Physician or other qualified health care professional attendance and supervision of hyperbaric oxygen therapy, per session	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1029 Hyperbaraic Oxygen Therapy	
99184	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	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1009 Deep Brain Stimulation and HHO-DE-MP-1088 Electroencephalogram (EEG) Technologies	
99199	Unlisted special service, procedure, or report	Prior authorization is required.		
99202	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 total time on the date of the encounter for code selection, 15-29 minutes of total time is spent on the date of the encounter.	Prior authorization is required for members under age 13 when performed by a Chiropractor. Reference policies for additional information.	HHO-DE-RP-1120 Chiropractic Benefits and Services	
99203	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 total time on the date of the encounter for code selection, 30-44 minutes of total time is spent on the date of the encounter.	Prior authorization is required for members under age 13 when performed by a Chiropractor. Reference policies for additional information.	HHO-DE-RP-1120 Chiropractic Benefits and Services	
99204	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 total time on the date of the encounter for code selection, 45-59 minutes of total time is spent on the date of the encounter.	Prior authorization is required for members under age 13 when performed by a Chiropractor. Reference policies for additional information.	HHO-DE-RP-1120 Chiropractic Benefits and Services	
99205	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 total time on the date of the encounter for code selection, 60-74 minutes of total time is spent on the date of the encounter	Prior authorization is required for members under age 13 when performed by a Chiropractor. Reference policies for additional information.	HHO-DE-RP-1120 Chiropractic Benefits and Services	
99211	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	Prior authorization is required for members under age 13 when performed by a Chiropractor. Reference policies for additional information.	HHO-DE-RP-1120 Chiropractic Benefits and Services	
99212	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 total time on the date of the encounter for code selection, 10-19 minutes of total time is spent on the date of the encounter.	Prior authorization is required for members under age 13 when performed by a Chiropractor. Reference policies for additional information.	HHO-DE-RP-1120 Chiropractic Benefits and Services	
99213	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 total time on the date of the encounter for code selection, 20-29 minutes of total time is spent on the date of the encounter.	Prior authorization is required for members under age 13 when performed by a Chiropractor. Reference policies for additional information.	HHO-DE-RP-1120 Chiropractic Benefits and Services	
99214	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 total time on the date of the encounter for code selection, 30-39 minutes of total time is spent on the date of the encounter.	Prior authorization is required for members under age 13 when performed by a Chiropractor. Reference policies for additional information.	HHO-DE-RP-1120 Chiropractic Benefits and Services	
99215	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 total time on the date of the encounter for code selection, 40-54 minutes of total time is spent on the date of the encounter.	Prior authorization is required for members under age 13 when performed by a Chiropractor. Reference policies for additional information.	HHO-DE-RP-1120 Chiropractic Benefits and Services	
99223	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.	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1143 Physician Certification and Recertification of Home Health Services	
99224	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.	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1143 Physician Certification and Recertification of Home Health Services	

99225	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.	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1143 Physician Certification and Recertification of Home Health Services	
99226	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.	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1143 Physician Certification and Recertification of Home Health Services	
99231	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.	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1143 Physician Certification and Recertification of Home Health Services	
99232	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.	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1143 Physician Certification and Recertification of Home Health Services	
99233	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.	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1143 Physician Certification and Recertification of Home Health Services	
99234	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.	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1143 Physician Certification and Recertification of Home Health Services	
99235	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.	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1143 Physician Certification and Recertification of Home Health Services	
99236	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.	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1143 Physician Certification and Recertification of Home Health Services	
99238	Hospital discharge day management; 30 minutes or less	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1143 Physician Certification and Recertification of Home Health Services	
99239	Hospital discharge day management; more than 30 minutes	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1143 Physician Certification and Recertification of Home Health Services	

99304	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.	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1143 Physician Certification and Recertification of Home Health Services	
99305	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.	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1143 Physician Certification and Recertification of Home Health Services	
99306	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.	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1143 Physician Certification and Recertification of Home Health Services	
99307	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.	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1143 Physician Certification and Recertification of Home Health Services	
99308	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.	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1143 Physician Certification and Recertification of Home Health Services	
99309	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.	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1143 Physician Certification and Recertification of Home Health Services	
99310	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.	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1143 Physician Certification and Recertification of Home Health Services	
99318	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.	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1143 Physician Certification and Recertification of Home Health Services	
99341	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.	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1143 Physician Certification and Recertification of Home Health Services	

99342	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.	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1143 Physician Certification and Recertification of Home Health Services	
99343	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.	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1143 Physician Certification and Recertification of Home Health Services	
99344	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.	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1143 Physician Certification and Recertification of Home Health Services	
99345	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.	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1143 Physician Certification and Recertification of Home Health Services	
99347	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.	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1143 Physician Certification and Recertification of Home Health Services	
99348	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.	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1143 Physician Certification and Recertification of Home Health Services	
99349	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.	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1143 Physician Certification and Recertification of Home Health Services	
99350	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.	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1143 Physician Certification and Recertification of Home Health Services	
99499	Evaluation and management service	Prior authorization is required.		
99600	Unlisted home visit	Prior authorization is required.		
J0219	Injection, avalglucosidase alfa-ngpt, 4 mg	Prior authorization is required.		
J0491	Unclassified biologics Injection, anifrolumab-fnia, 1 mg	Prior authorization is required.		
0001U	Red blood cell antigen typing, DNA, human erythrocyte antigen gene analysis of 35 antigens from 11 blood groups, utilizing whole blood, common RBC alleles reported	Prior authorization is required.		
0004M	Scoliosis, DNA analysis of 53 single nucleotide polymorphisms (SNPs), using saliva, prognostic algorithm reported as a risk score	Prior authorization is required.		
0005U	Oncology (prostate) gene expression profile by real-time RT-PCR of 3 genes (ERG, PCA3 and SPDEF), urine, algorithm reported as risk score	Prior authorization is required.		
0006M	Oncology (hepatic), mRNA expression levels of 161 genes, utilizing fresh hepatocellular carcinoma tumor tissue, with alpha-fetoprotein level, algorithm reported as a risk classifier	Prior authorization is required.		

0007M	Oncology (gastrointestinal neuroendocrine tumors), real-time PCR expression analysis of 51 genes, utilizing whole peripheral blood, algorithm reported as a nomogram of tumor disease index	Prior authorization is required.		
0007U	Drug test(s), presumptive, with definitive confirmation of positive results, any number of drug classes, urine, includes specimen verification including DNA authentication in comparison to buccal DNA, per date of service	Prior authorization is required.		
0008U	Helicobacter pylori detection and antibiotic resistance, DNA, 16S and 23S rRNA, gyrA, pbp1, rdxA and rpoB, next generation sequencing, formalin-fixed paraffin-embedded or fresh tissue or fecal sample, predictive, reported as positive or negative for resistance to clarithromycin, fluoroquinolones, metronidazole, amoxicillin, tetracycline and rifabutin	Prior authorization is required.		
0009U	Oncology (breast cancer), ERBB2 (HER2) copy number by FISH, tumor cells from formalin-fixed paraffin-embedded tissue isolated using image-based dielectrophoresis (DEP) sorting, reported as ERBB2 gene amplified or non-amplified	Prior authorization is required.		
0010U	Infectious disease (bacterial), strain typing by whole genome sequencing, phylogenetic-based report of strain relatedness, per submitted isolate	Prior authorization is required.		
0011M	Oncology, prostate cancer, mRNA expression assay of 12 genes (10 content and 2 housekeeping), RT-PCR test utilizing blood plasma and urine, algorithms to predict high-grade prostate cancer risk	Prior authorization is required.		
0012M	Oncology (urothelial), mRNA, gene expression profiling by real-time quantitative PCR of five genes (MDK, HOXA13, CDC2 [CDK1], IGFBP5 and CXCR2), utilizing urine, algorithm reported as a risk score for having urothelial carcinoma	Prior authorization is required.		
0013M	Oncology (urothelial), mRNA, gene expression profiling by real-time quantitative PCR of five genes (MDK, HOXA13, CDC2 [CDK1], IGFBP5 and CXCR2), utilizing urine, algorithm reported as a risk score for having recurrent urothelial carcinoma	Prior authorization is required.		
0016U	Oncology (hematolymphoid neoplasia), RNA, BCR/ABL1 major and minor breakpoint fusion transcripts, quantitative PCR amplification, blood or bone marrow, report of fusion not detected or detected with quantitation	Prior authorization is required.		
0017U	Oncology (hematolymphoid neoplasia), JAK2 mutation, DNA, PCR amplification of exons 12-14 and sequence analysis, blood or bone marrow, report of JAK2 mutation not detected or detected	Prior authorization is required.		
0018U	Oncology (thyroid), microRNA profiling by RT-PCR of 10 microRNA sequences, utilizing fine needle aspirate, algorithm reported as a positive or negative result for moderate to high risk of malignancy	Prior authorization is required.		
0019U	Oncology, RNA, gene expression by whole transcriptome sequencing, formalin-fixed paraffin-embedded tissue or fresh frozen tissue, predictive algorithm reported as potential targets for therapeutic agents	Prior authorization is required.		
0022U	Targeted genomic sequence analysis panel, non-small cell lung neoplasia, DNA and RNA analysis, 23 genes, interrogation for sequence variants and rearrangements, reported as presence or absence of variants and associated therapy(ies) to consider	Prior authorization is required.		
0023U	Oncology (acute myelogenous leukemia), DNA, genotyping of internal tandem duplication, p.D835, p.I836, using mononuclear cells, reported as detection or non-detection of FLT3 mutation and indication for or against the use of midostaurin	Prior authorization is required.		
0026U	Oncology (thyroid), DNA and mRNA of 112 genes, next-generation sequencing, fine needle aspirate of thyroid nodule, algorithmic analysis reported as a categorical result ("Positive, high probability of malignancy" or "Negative, low probability of malignancy")	Prior authorization is required.		
0027U	JAK2 (Janus kinase 2) (eg, myeloproliferative disorder) gene analysis, targeted sequence analysis exons 12-15	Prior authorization is required.		
0029U	Drug metabolism (adverse drug reactions and drug response), targeted sequence analysis (ie, CYP1A2, CYP2C19, CYP2C9, CYP2D6, CYP3A4, CYP3A5, CYP4F2, SLCO1B1, VKORC1 and rs12777823)	Prior authorization is required.		
0030U	Drug metabolism (warfarin drug response), targeted sequence analysis (ie, CYP2C9, CYP4F2, VKORC1, rs12777823)	Prior authorization is required.		
0031U	CYP1A2 (cytochrome P450 family 1, subfamily A, member 2) (eg, drug metabolism) gene analysis, common variants (ie, *1F, *1K, *6, *7)	Prior authorization is required.		
0032U	COMT (catechol-O-methyltransferase) (eg, drug metabolism) gene analysis, c.472G>A (rs4680) variant	Prior authorization is required.		
0033U	HTR2A (5-hydroxytryptamine receptor 2A), HTR2C (5-hydroxytryptamine receptor 2C) (eg, citalopram metabolism) gene analysis, common variants (ie, HTR2A rs7997012 [c.614-2211T>C], HTR2C rs3813929 [c.-759C>T] and rs1414334 [c.551-3008C>G])	Prior authorization is required.		
0034U	TPMT (thiopurine S-methyltransferase), NUDT15 (nudix hydroxylase 15) (eg, thiopurine metabolism) gene analysis, common variants (ie, TPMT *2, *3A, *3B, *3C, *4, *5, *6, *8, *12; NUDT15 *3, *4, *5)	Prior authorization is required.		
0036U	Exome (ie, somatic mutations), paired formalin-fixed paraffin-embedded tumor tissue and normal specimen, sequence analyses	Prior authorization is required.		
0037U	Targeted genomic sequence analysis, solid organ neoplasm, DNA analysis of 324 genes, interrogation for sequence variants, gene copy number amplifications, gene rearrangements, microsatellite instability and tumor mutational burden	Prior authorization is required.		
0040U	BCR/ABL1 (t(9;22)) (eg, chronic myelogenous leukemia) translocation analysis, major breakpoint, quantitative	Prior authorization is required.		
0042T	CT Perfusion Brain	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.

0045U	Oncology (breast ductal carcinoma in situ), mRNA, gene expression profiling by real-time RT-PCR of 12 genes (7 content and 5 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as recurrence score	Prior authorization is required.		
0046U	FLT3 (fms-related tyrosine kinase 3) (eg, acute myeloid leukemia) internal tandem duplication (ITD) variants, quantitative	Prior authorization is required.		
0047U	Oncology (prostate), mRNA, gene expression profiling by real-time RT-PCR of 17 genes (12 content and 5 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a risk score	Prior authorization is required.		
0048U	Oncology (solid organ neoplasia), DNA, targeted sequencing of protein-coding exons of 468 cancer-associated genes, including interrogation for somatic mutations and microsatellite instability, matched with normal specimens, utilizing formalin-fixed paraffin-embedded tumor tissue, report of clinically significant mutation(s)	Prior authorization is required.		
0049U	NPM1 (nucleophosmin) (eg, acute myeloid leukemia) gene analysis, quantitative	Prior authorization is required.		
0050U	Targeted genomic sequence analysis panel, acute myelogenous leukemia, DNA analysis, 194 genes, interrogation for sequence variants, copy number variants or rearrangements	Prior authorization is required.		
0053U	Oncology (prostate cancer), FISH analysis of 4 genes (ASAP1, HDAC9, CHD1 and PTEN), needle biopsy specimen, algorithm reported as probability of higher tumor grade	Prior authorization is required.		
0055U	Cardiology (heart transplant), cell-free DNA, PCR assay of 96 DNA target sequences (94 single nucleotide polymorphism targets and two control targets), plasma	Prior authorization is required.		
0060U	Twin zygosity, genomic-targeted sequence analysis of chromosome 2, using circulating cell-free fetal DNA in maternal blood	Prior authorization is required.		
0068U	Candida species panel (C. albicans, C. glabrata, C. parapsilosis, C. kruseii, C. tropicalis and C. auris), amplified probe technique with qualitative report of the presence or absence of each species	Prior authorization is required.		
0069U	Candida species panel (C. albicans, C. glabrata, C. parapsilosis, C. kruseii, C. tropicalis and C. auris), amplified probe technique with qualitative report of the presence or absence of each species	Prior authorization is required.		
0070U	CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (eg, drug metabolism) gene analysis, common and select rare variants (ie, *2, *3, *4, *4N, *5, *6, *7, *8, *9, *10, *11, *12, *13, *14A, *14B, *15, *17, *29, *35, *36, *41, *57, *61, *63, *68, *83, *xN)	Prior authorization is required.		
0071U	CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (eg, drug metabolism) gene analysis, full gene sequence (List separately in addition to code for primary procedure)	Prior authorization is required.		
0072U	CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (eg, drug metabolism) gene analysis, targeted sequence analysis (ie, CYP2D6-2D7 hybrid gene) (List separately in addition to code for primary procedure)	Prior authorization is required.		
0073U	CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (eg, drug metabolism) gene analysis, targeted sequence analysis (ie, CYP2D7-2D6 hybrid gene) (List separately in addition to code for primary procedure)	Prior authorization is required.		
0074U	CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (eg, drug metabolism) gene analysis, targeted sequence analysis (ie, non-duplicated gene when duplication/multiplication is trans) (List separately in addition to code for primary procedure)	Prior authorization is required.		
0075U	CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (eg, drug metabolism) gene analysis, targeted sequence analysis (ie, 5' gene duplication/multiplication) (List separately in addition to code for primary procedure)	Prior authorization is required.		
0076U	CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (eg, drug metabolism) gene analysis, targeted sequence analysis (ie, 3' gene duplication/multiplication) (List separately in addition to code for primary procedure)	Prior authorization is required.		
0078U	Pain management (opioid-use disorder) genotyping panel, 16 common variants (ie, ABCB1, COMT, DAT1, DBH, DOR, DRD1, DRD2, DRD4, GABA, GAL, HTR2A, HTTLPR, MTHFR, MUOR, OPRK1, OPRM1), buccal swab or other germline tissue sample, algorithm reported as positive or negative risk of opioid-use disorder	Prior authorization is required.		
0079U	Comparative DNA analysis using multiple selected single-nucleotide polymorphisms (SNPs), urine and buccal DNA, for specimen identity verification	Prior authorization is required.		
0084U	Red blood cell antigen typing, DNA, genotyping of 10 blood groups with phenotype prediction of 37 red blood cell antigens	Prior authorization is required.		
0086U	Infectious disease (bacterial and fungal), organism identification, blood culture, using rRNA FISH, 6 or more organism targets, reported as positive or negative with phenotypic minimum inhibitory concentration (MIC)-based antimicrobial susceptibility	Prior authorization is required.		
0087U	Cardiology (heart transplant), mRNA gene expression profiling by microarray of 1283 genes, transplant biopsy tissue, allograft rejection and injury algorithm reported as a probability score	Prior authorization is required.		
0088U	Transplantation medicine (kidney allograft rejection), microarray gene expression profiling of 1494 genes, utilizing transplant biopsy tissue, algorithm reported as a probability score for rejection	Prior authorization is required.		
0089U	Oncology (melanoma), gene expression profiling by RTqPCR, PRAME and LINC00518, superficial collection using adhesive patch(es)	Prior authorization is required.		

0090U	Oncology (cutaneous melanoma), mRNA gene expression profiling by RT-PCR of 23 genes (14 content and 9 housekeeping), utilizing formalin-fixed paraffin-embedded (FFPE) tissue, algorithm reported as a categorical result (ie, benign, intermediate, malignant)	Prior authorization is required.		
0094U	Oncology (colorectal) screening, cell enumeration of circulating tumor cells, utilizing whole blood, algorithm, for the presence of adenoma or cancer, reported as a positive or negative result	Prior authorization is required.		
0095T	Removal of total disc arthroplasty (artificial disc), anterior approach, each additional interspace, cervical (List separately in addition to code for primary procedure)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
0096U	Oncology (colorectal) screening, cell enumeration of circulating tumor cells, utilizing whole blood, algorithm, for the presence of adenoma or cancer, reported as a positive or negative result	Prior authorization is required.		
0098T	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, each additional interspace, cervical (List separately in addition to code for primary procedure)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
0101U	Hereditary colon cancer disorders (eg, Lynch syndrome, PTEN hamartoma syndrome, Cowden syndrome, familial adenomatosis polyposis), genomic sequence analysis panel utilizing a combination of NGS, Sanger, MLPA and array CGH, with mRNA analytics to resolve variants of unknown significance when indicated (15 genes [sequencing and deletion/duplication], EPCAM and GREM1 [deletion/duplication only])	Prior authorization is required.		
0102U	Hereditary breast cancer-related disorders (eg, hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer), genomic sequence analysis panel utilizing a combination of NGS, Sanger, MLPA and array CGH, with mRNA analytics to resolve variants of unknown significance when indicated (17 genes [sequencing and deletion/duplication])	Prior authorization is required.		
0103U	Hereditary ovarian cancer (eg, hereditary ovarian cancer, hereditary endometrial cancer), genomic sequence analysis panel utilizing a combination of NGS, Sanger, MLPA and array CGH, with mRNA analytics to resolve variants of unknown significance when indicated (24 genes [sequencing and deletion/duplication], EPCAM [deletion/duplication only])	Prior authorization is required.		
0105U	Nephrology (chronic kidney disease), multiplex electrochemiluminescent immunoassay (ECLIA) of tumor necrosis factor receptor 1A, receptor superfamily 2 (TNFR1, TNFR2) and kidney injury molecule-1 (KIM-1) combined with longitudinal clinical data, including APOL1 genotype if available and plasma (isolated fresh or frozen), algorithm reported as probability score for rapid kidney function decline (RKFD)	Prior authorization is required.		
0109U	Infectious disease (Aspergillus species), real-time PCR for detection of DNA from 4 species (A. fumigatus, A. terreus, A. niger and A. flavus), blood, lavage fluid, or tissue, qualitative reporting of presence or absence of each species	Prior authorization is required.		
0111U	Oncology (colon cancer), targeted KRAS (codons 12, 13 and 61) and NRAS (codons 12, 13 and 61) gene analysis, utilizing formalin-fixed paraffin-embedded tissue	Prior authorization is required.		
0112U	Infectious agent detection and identification, targeted sequence analysis (16S and 18S rRNA genes) with drug-resistance gene	Prior authorization is required.		
0113U	Oncology (prostate), measurement of PCA3 and TMPRSS2-ERG in urine and PSA in serum following prostatic massage, by RNA amplification and fluorescence-based detection, algorithm reported as risk score	Prior authorization is required.		
0114U	Gastroenterology (Barrett's esophagus), VIM and CCNA1 methylation analysis, esophageal cells, algorithm reported as likelihood for Barrett's esophagus	Prior authorization is required.		
0118U	Transplantation medicine, quantification of donor-derived cell-free DNA using whole genome next-generation sequencing, plasma, reported as percentage of donor-derived cell-free DNA in the total cell-free DNA	Prior authorization is required.		
0120U	Oncology (B-cell lymphoma classification), mRNA, gene expression profiling by fluorescent probe hybridization of 58 genes (45 content and 13 housekeeping genes), formalin-fixed paraffin-embedded tissue, algorithm reported as likelihood for primary mediastinal B-cell lymphoma (PMBCL) and diffuse large B-cell lymphoma (DLBCL) with cell of origin subtyping in the latter	Prior authorization is required.		
0129U	Hereditary breast cancer-related disorders (eg, hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer), genomic sequence analysis and deletion/duplication analysis panel (ATM, BRCA1, BRCA2, CDH1, CHEK2, PALB2, PTEN and TP53)	Prior authorization is required.		
0130U	Hereditary colon cancer disorders (eg, Lynch syndrome, PTEN hamartoma syndrome, Cowden syndrome, familial adenomatosis polyposis), targeted mRNA sequence analysis panel (APC, CDH1, CHEK2, MLH1, MSH2, MSH6, MUTYH, PMS2, PTEN and TP53) (List separately in addition to code for primary procedure)	Prior authorization is required.		
0131U	Hereditary breast cancer-related disorders (eg, hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer), targeted mRNA sequence analysis panel (13 genes) (List separately in addition to code for primary procedure)	Prior authorization is required.		
0132U	Hereditary ovarian cancer-related disorders (eg, hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer), targeted mRNA sequence analysis panel (17 genes) (List separately in addition to code for primary procedure)	Prior authorization is required.		
0133U	Hereditary prostate cancer-related disorders, targeted mRNA sequence analysis panel (11 genes) (List separately in addition to code for primary procedure)	Prior authorization is required.		

0134U	Hereditary pan cancer (eg, hereditary breast and ovarian cancer, hereditary endometrial cancer, hereditary colorectal cancer), targeted mRNA sequence analysis panel (18 genes) (List separately in addition to code for primary procedure)	Prior authorization is required.		
0135U	Hereditary gynecological cancer (eg, hereditary breast and ovarian cancer, hereditary endometrial cancer, hereditary colorectal cancer), targeted mRNA sequence analysis panel (12 genes) (List separately in addition to code for primary procedure)	Prior authorization is required.		
0136U	ATM (ataxia telangiectasia mutated) (eg, ataxia telangiectasia) mRNA sequence analysis (List separately in addition to code for primary procedure)	Prior authorization is required.		
0137U	PALB2 (partner and localizer of BRCA2) (eg, breast and pancreatic cancer) mRNA sequence analysis (List separately in addition to code for primary procedure)	Prior authorization is required.		
0138U	BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian cancer) mRNA sequence analysis (List separately in addition to code for primary procedure)	Prior authorization is required.		
0140U	Infectious disease (fungi), fungal pathogen identification, DNA (15 fungal targets), blood culture, amplified probe technique, each target reported as detected or not detected	Prior authorization is required.		
0141U	Infectious disease (bacteria and fungi), gram-positive organism identification and drug resistance element detection, DNA (20 gram-positive bacterial targets, 4 resistance genes, 1 pan gram-negative bacterial target, 1 pan Candida target), blood culture, amplified probe technique, each target reported as detected or not detected	Prior authorization is required.		
0142U	Infectious disease (bacteria and fungi), gram-negative bacterial identification and drug resistance element detection, DNA (21 gram-negative bacterial targets, 6 resistance genes, 1 pan gram-positive bacterial target, 1 pan Candida target), amplified probe technique, each target reported as detected or not detected	Prior authorization is required.		
0152U	Infectious disease (bacteria, fungi, parasites and DNA viruses), microbial cell-free DNA, plasma, untargeted next-generation sequencing, report for significant positive pathogens	Prior authorization is required.		
0153U	Oncology (breast), mRNA, gene expression profiling by next-generation sequencing of 101 genes, utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a triple negative breast cancer clinical subtype(s) with information on immune cell involvement	Prior authorization is required.		
0154U	Oncology (urothelial cancer), RNA, analysis by real-time RT-PCR of the FGFR3 (fibroblast growth factor receptor 3) gene analysis (ie, p.R248C [c.742C>T], p.S249C [c.746C>G], p.G370C [c.1108G>T], p.Y373C [c.1118A>G], FGFR3-TACC3v1 and FGFR3-TACC3v3), utilizing formalin-fixed paraffin-embedded urothelial cancer tumor tissue, reported as FGFR gene alteration status	Prior authorization is required.		
0155U	Oncology (breast cancer), DNA, PIK3CA (phosphatidylinositol-4,5-bisphosphate 3-kinase, catalytic subunit alpha) (eg, breast cancer) gene analysis (ie, p.C420R, p.E542K, p.E545A, p.E545D [g.1635G>T only], p.E545G, p.E545K, p.Q546E, p.Q546R, p.H1047L, p.H1047R, p.H1047Y), utilizing formalin-fixed paraffin-embedded breast tumor tissue, reported as PIK3CA gene mutation status	Prior authorization is required.		
0156U	Copy number (eg, intellectual disability, dysmorphology), sequence analysis	Prior authorization is required.		
0157U	APC (APC regulator of WNT signaling pathway) (eg, familial adenomatosis polyposis [FAP]) mRNA sequence analysis (List separately in addition to code for primary procedure)	Prior authorization is required.		
0158U	MLH1 (mutL homolog 1) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) mRNA sequence analysis (List separately in addition to code for primary procedure)	Prior authorization is required.		
0159U	MSH2 (mutS homolog 2) (eg, hereditary colon cancer, Lynch syndrome) mRNA sequence analysis (List separately in addition to code for primary procedure)	Prior authorization is required.		
0160U	MSH6 (mutS homolog 6) (eg, hereditary colon cancer, Lynch syndrome) mRNA sequence analysis (List separately in addition to code for primary procedure)	Prior authorization is required.		
0161U	PMS2 (PMS1 homolog 2, mismatch repair system component) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) mRNA sequence analysis (List separately in addition to code for primary procedure)	Prior authorization is required.		
0162U	Hereditary colon cancer (Lynch syndrome), targeted mRNA sequence analysis panel (MLH1, MSH2, MSH6, PMS2) (List separately in addition to code for primary procedure)	Prior authorization is required.		
0163T	Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), each additional interspace, lumbar (List separately in addition to code for primary procedure)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
0164T	Removal of total disc arthroplasty, (artificial disc), anterior approach, each additional interspace, lumbar (List separately in addition to code for primary procedure)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
0165T	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, each additional interspace, lumbar (List separately in addition to code for primary procedure)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
0169U	NUDT15 (nudix hydrolase 15) and TPMT (thiopurine S-methyltransferase) (eg, drug metabolism) gene analysis, common variants	Prior authorization is required.		
0170U	Neurology (autism spectrum disorder [ASD]), RNA, next-generation sequencing, saliva, algorithmic analysis and results reported as predictive probability of ASD diagnosis	Prior authorization is required.		
0171U	Targeted genomic sequence analysis panel, acute myeloid leukemia, myelodysplastic syndrome and myeloproliferative neoplasms, DNA analysis, 23 genes, interrogation for sequence variants, rearrangements and minimal residual disease, reported as presence/absence	Prior authorization is required.		

0172U	Oncology (solid tumor as indicated by the label), somatic mutation analysis of BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) and analysis of homologous recombination deficiency pathways, DNA, formalin-fixed paraffin-embedded tissue, algorithm quantifying tumor genomic instability score	Prior authorization is required.		
0173U	Psychiatry (ie, depression, anxiety), genomic analysis panel, includes variant analysis of 14 genes	Prior authorization is required.		
0175U	Psychiatry (eg, depression, anxiety), genomic analysis panel, variant analysis of 15 genes	Prior authorization is required.		
0177U	Oncology (breast cancer), DNA, PIK3CA (phosphatidylinositol-4,5-bisphosphate 3-kinase catalytic subunit alpha) gene analysis of 11 gene variants utilizing plasma, reported as PIK3CA gene mutation status	Prior authorization is required.		
0179U	Oncology (non-small cell lung cancer), cell-free DNA, targeted sequence analysis of 23 genes (single nucleotide variations, insertions and deletions, fusions without prior knowledge of partner/breakpoint, copy number variations), with report of significant mutation(s)	Prior authorization is required.		
0180U	Red cell antigen (ABO blood group) genotyping (ABO), gene analysis Sanger/chain termination/conventional sequencing, ABO (ABO, alpha 1-3-N-acetylgalactosaminyltransferase and alpha 1-3-galactosyltransferase) gene, including subtyping, 7 exons	Prior authorization is required.		
0181U	Red cell antigen (Colton blood group) genotyping (CO), gene analysis, AQP1 (aquaporin 1 [Colton blood group]) exon 1	Prior authorization is required.		
0182U	Red cell antigen (Cromer blood group) genotyping (CROM), gene analysis, CD55 (CD55 molecule [Cromer blood group]) exons 1-10	Prior authorization is required.		
0183U	Red cell antigen (Diego blood group) genotyping (DI), gene analysis, SLC4A1 (solute carrier family 4 member 1 [Diego blood group]) exon 19	Prior authorization is required.		
0184U	Red cell antigen (Dombrock blood group) genotyping (DO), gene analysis, ART4 (ADP-ribosyltransferase 4 [Dombrock blood group]) exon 2	Prior authorization is required.		
0185U	Red cell antigen (H blood group) genotyping (FUT1), gene analysis, FUT1 (fucosyltransferase 1 [H blood group]) exon 4	Prior authorization is required.		
0186U	Red cell antigen (H blood group) genotyping (FUT2), gene analysis, FUT2 (fucosyltransferase 2) exon 2	Prior authorization is required.		
0187U	Red cell antigen (Duffy blood group) genotyping (FY), gene analysis, ACKR1 (atypical chemokine receptor 1 [Duffy blood group]) exons 1-2	Prior authorization is required.		
0188U	Red cell antigen (Gerbich blood group) genotyping (GE), gene analysis, GYPC (glycophorin C [Gerbich blood group]) exons 1-4	Prior authorization is required.		
0189U	Red cell antigen (MNS blood group) genotyping (GYPA), gene analysis, GYPA (glycophorin A [MNS blood group]) introns 1, 5, exon 2	Prior authorization is required.		
0190U	Red cell antigen (MNS blood group) genotyping (GYPB), gene analysis, GYPB (glycophorin B [MNS blood group]) introns 1, 5, pseudoexon 3	Prior authorization is required.		
0191U	Red cell antigen (Indian blood group) genotyping (IN), gene analysis, CD44 (CD44 molecule [Indian blood group]) exons 2, 3, 6	Prior authorization is required.		
0192U	Red cell antigen (Kidd blood group) genotyping (JK), gene analysis, SLC14A1 (solute carrier family 14 member 1 [Kidd blood group]) gene promoter, exon 9	Prior authorization is required.		
0193U	Red cell antigen (JR blood group) genotyping (JR), gene analysis, ABCG2 (ATP binding cassette subfamily G member 2 [Junior blood group]) exons 2-26	Prior authorization is required.		
0194U	Red cell antigen (Kell blood group) genotyping (KEL), gene analysis, KEL (Kell metallo-endopeptidase [Kell blood group]) exon 8	Prior authorization is required.		
0195U	KLF1 (Kruppel-like factor 1), targeted sequencing (ie, exon 13)	Prior authorization is required.		
0196U	Red cell antigen (Lutheran blood group) genotyping (LU), gene analysis, BCAM (basal cell adhesion molecule [Lutheran blood group]) exon 3	Prior authorization is required.		
0197U	Red cell antigen (Landsteiner-Wiener blood group) genotyping (LW), gene analysis, ICAM4 (intercellular adhesion molecule 4 [Landsteiner-Wiener blood group]) exon 1	Prior authorization is required.		
0198U	Red cell antigen (RH blood group) genotyping (RHD and RHCE), gene analysis Sanger/chain termination/conventional sequencing, RHD (Rh blood group D antigen) exons 1-10 and RHCE (Rh blood group CcEe antigens) exon 5	Prior authorization is required.		
0199U	Red cell antigen (Scianna blood group) genotyping (SC), gene analysis, ERMAP (erythroblast membrane associated protein [Scianna blood group]) exons 4, 12	Prior authorization is required.		
0200U	Red cell antigen (Kx blood group) genotyping (XK), gene analysis, XK (X-linked Kx blood group) exons 1-3	Prior authorization is required.		
0201U	Red cell antigen (Yt blood group) genotyping (YT), gene analysis, ACHE (acetylcholinesterase [Cartwright blood group]) exon 2	Prior authorization is required.		
0203U	Autoimmune (inflammatory bowel disease), mRNA, gene expression profiling by quantitative RT-PCR, 17 genes (15 target and 2 reference genes), whole blood, reported as a continuous risk score and classification of inflammatory bowel disease aggressiveness	Prior authorization is required.		
0204U	Oncology (thyroid), mRNA, gene expression analysis of 593 genes (including BRAF, RAS, RET, PAX8 and NTRK) for sequence variants and rearrangements, utilizing fine needle aspirate, reported as detected or not detected	Prior authorization is required.		
0205U	Ophthalmology (age-related macular degeneration), analysis of 3 gene variants (2 CFH gene, 1 ARMS2 gene), using PCR and MALDI-TOF, buccal swab, reported as positive or negative for neovascular age-related macular-degeneration risk associated with zinc supplements	Prior authorization is required.		

0209U	Cytogenomic constitutional (genome-wide) analysis, interrogation of genomic regions for copy number, structural changes and areas of homozygosity for chromosomal abnormalities	Prior authorization is required.		
0211U	Oncology (pan-tumor), DNA and RNA by next-generation sequencing, utilizing formalin-fixed paraffin-embedded tissue, interpretative report for single nucleotide variants, copy number alterations, tumor mutational burden and microsatellite instability, with therapy association	Prior authorization is required.		
0212U	Rare diseases (constitutional/heritable disorders), whole genome and mitochondrial DNA sequence analysis, including small sequence changes, deletions, duplications, short tandem repeat gene expansions and variants in non-uniquely mappable regions, blood or saliva, identification and categorization of genetic variants, proband	Prior authorization is required.		
0213U	Rare diseases (constitutional/heritable disorders), whole genome and mitochondrial DNA sequence analysis, including small sequence changes, deletions, duplications, short tandem repeat gene expansions and variants in non-uniquely mappable regions, blood or saliva, identification and categorization of genetic variants, each comparator genome (eg, parent, sibling)	Prior authorization is required.		
0214U	Rare diseases (constitutional/heritable disorders), whole exome and mitochondrial DNA sequence analysis, including small sequence changes, deletions, duplications, short tandem repeat gene expansions and variants in non-uniquely mappable regions, blood or saliva, identification and categorization of genetic variants, proband	Prior authorization is required.		
0215U	Rare diseases (constitutional/heritable disorders), whole exome and mitochondrial DNA sequence analysis, including small sequence changes, deletions, duplications, short tandem repeat gene expansions and variants in non-uniquely mappable regions, blood or saliva, identification and categorization of genetic variants, each comparator exome (eg, parent, sibling)	Prior authorization is required.		
0216U	Neurology (inherited ataxias), genomic DNA sequence analysis of 12 common genes including small sequence changes, deletions, duplications, short tandem repeat gene expansions and variants in non-uniquely mappable regions, blood or saliva, identification and categorization of genetic variants	Prior authorization is required.		
0217U	Neurology (inherited ataxias), genomic DNA sequence analysis of 51 genes including small sequence changes, deletions, duplications, short tandem repeat gene expansions and variants in non-uniquely mappable regions, blood or saliva, identification and categorization of genetic variants	Prior authorization is required.		
0218U	Neurology (muscular dystrophy), DMD gene sequence analysis, including small sequence changes, deletions, duplications and variants in non-uniquely mappable regions, blood or saliva, identification and characterization of genetic variants	Prior authorization is required.		
0219U	Infectious agent (human immunodeficiency virus), targeted viral next-generation sequence analysis (ie, protease [PR], reverse transcriptase [RT], integrase [INT]), algorithm reported as prediction of antiviral drug susceptibility	Prior authorization is required.		
0221U	Red cell antigen (ABO blood group) genotyping (ABO), gene analysis, next-generation sequencing, ABO (ABO, alpha 1-3-N-acetylgalactosaminyltransferase and alpha 1-3-galactosyltransferase) gene	Prior authorization is required.		
0222U	Red cell antigen (RH blood group) genotyping (RHD and RHCE), gene analysis, next-generation sequencing, RH proximal promoter, exons 1-10, portions of introns 2-3	Prior authorization is required.		
0227U	Drug assay, presumptive, 30 or more drugs or metabolites, urine, liquid chromatography with tandem mass spectrometry (LC-MS/MS) using multiple reaction monitoring (MRM), with drug or metabolite description, includes sample validation	Prior authorization is required.		
0229U	BCAT1 (Branched chain amino acid transaminase 1) and IKZF1 (IKAROS family zinc finger 1) (eg, colorectal cancer) promoter methylation analysis	Prior authorization is required.		
0230U	AR (androgen receptor) (eg, spinal and bulbar muscular atrophy, Kennedy disease, X chromosome inactivation), full sequence analysis, including small sequence changes in exonic and intronic regions, deletions, duplications, short tandem repeat (STR) expansions, mobile element insertions and variants in non-uniquely mappable regions	Prior authorization is required.		
0231U	CACNA1A (calcium voltage-gated channel subunit alpha 1A) (eg, spinocerebellar ataxia), full gene analysis, including small sequence changes in exonic and intronic regions, deletions, duplications, short tandem repeat (STR) gene expansions, mobile element insertions and variants in non-uniquely mappable regions	Prior authorization is required.		
0232T	Injection(s), platelet rich plasma, any site, including image guidance, harvesting and preparation when performed	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1132 Skin Replacement Therapy For Chronic Non healing Wounds in The Outpatient Setting	
0232U	CSTB (cystatin B) (eg, progressive myoclonic epilepsy type 1A, Unverricht-Lundborg disease), full gene analysis, including small sequence changes in exonic and intronic regions, deletions, duplications, short tandem repeat (STR) expansions, mobile element insertions and variants in non-uniquely mappable regions	Prior authorization is required.		
0233U	FXN (frataxin) (eg, Friedreich ataxia), gene analysis, including small sequence changes in exonic and intronic regions, deletions, duplications, short tandem repeat (STR) expansions, mobile element insertions and variants in non-uniquely mappable regions	Prior authorization is required.		
0234U	MECP2 (methyl CpG binding protein 2) (eg, Rett syndrome), full gene analysis, including small sequence changes in exonic and intronic regions, deletions, duplications, mobile element insertions and variants in non-uniquely mappable regions	Prior authorization is required.		
0235U	PTEN (phosphatase and tensin homolog) (eg, Cowden syndrome, PTEN hamartoma tumor syndrome), full gene analysis, including small sequence changes in exonic and intronic regions, deletions, duplications, mobile element insertions and variants in non-uniquely mappable regions	Prior authorization is required.		

0236U	SMN1 (survival of motor neuron 1, telomeric) and SMN2 (survival of motor neuron 2, centromeric) (eg, spinal muscular atrophy) full gene analysis, including small sequence changes in exonic and intronic regions, duplications, deletions and mobile element insertions	Prior authorization is required.		
0237U	Cardiac ion channelopathies (eg, Brugada syndrome, long QT syndrome, short QT syndrome, catecholaminergic polymorphic ventricular tachycardia), genomic sequence analysis panel including ANK2, CASQ2, CAV3, KCNE1, KCNE2, KCNH2, KCNJ2, KCNQ1, RYR2 and SCN5A, including small sequence changes in exonic and intronic regions, deletions, duplications, mobile element insertions and variants in non-uniquely mappable regions	Prior authorization is required.		
0238U	Oncology (Lynch syndrome), genomic DNA sequence analysis of MLH1, MSH2, MSH6, PMS2 and EPCAM, including small sequence changes in exonic and intronic regions, deletions, duplications, mobile element insertions and variants in non-uniquely mappable regions	Prior authorization is required.		
0239U	Targeted genomic sequence analysis panel, solid organ neoplasm, cell-free DNA, analysis of 311 or more genes, interrogation for sequence variants, including substitutions, insertions, deletions, select rearrangements and copy number variations	Prior authorization is required.		
0242U	Targeted genomic sequence analysis panel, solid organ neoplasm, cell-free circulating DNA analysis of 55-74 genes, interrogation for sequence variants, gene copy number amplifications and gene rearrangements	Prior authorization is required.		
0244U	Oncology (solid organ), DNA, comprehensive genomic profiling, 257 genes, interrogation for single-nucleotide variants, insertions/deletions, copy number alterations, gene rearrangements, tumor-mutational burden and microsatellite instability, utilizing formalin-fixed paraffin-embedded tumor tissue	Prior authorization is required.		
0245U	Oncology (thyroid), mutation analysis of 10 genes and 37 RNA fusions and expression of 4 mRNA markers using next-generation sequencing, fine needle aspirate, report includes associated risk of malignancy expressed as a percentage	Prior authorization is required.		
0246U	Red blood cell antigen typing, DNA, genotyping of at least 16 blood groups with phenotype prediction of at least 51 red blood cell antigens	Prior authorization is required.		
0250U	Oncology (solid organ neoplasm), targeted genomic sequence DNA analysis of 505 genes, interrogation for somatic alterations (SNVs [single nucleotide variant], small insertions and deletions, one amplification and four translocations), microsatellite instability and tumor-mutation burden	Prior authorization is required.		
0252U	Fetal aneuploidy short tandem-repeat comparative analysis, fetal DNA from products of conception, reported as normal (euploidy), monosomy, trisomy, or partial deletion/duplication, mosaicism and segmental aneuploidy	Prior authorization is required.		
0253U	Reproductive medicine (endometrial receptivity analysis), RNA gene expression profile, 238 genes by next-generation sequencing, endometrial tissue, predictive algorithm reported as endometrial window of implantation (eg, pre-receptive, receptive, post-receptive)	Prior authorization is required.		
0254U	Reproductive medicine (preimplantation genetic assessment), analysis of 24 chromosomes using embryonic DNA genomic sequence analysis for aneuploidy and a mitochondrial DNA score in euploid embryos, results reported as normal (euploidy), monosomy, trisomy, or partial deletion/duplication, mosaicism and segmental aneuploidy, per embryo tested	Prior authorization is required.		
0258U	Autoimmune (psoriasis), mRNA, next-generation sequencing, gene expression profiling of 50-100 genes, skin-surface collection using adhesive patch, algorithm reported as likelihood of response to psoriasis biologics	Prior authorization is required.		
0260U	Rare diseases (constitutional/heritable disorders), identification of copy number variations, inversions, insertions, translocations and other structural variants by optical genome mapping	Prior authorization is required.		
0262U	Oncology (solid tumor), gene expression profiling by real-time RT-PCR of 7 gene pathways (ER, AR, PI3K, MAPK, HH, TGFB, Notch), formalin-fixed paraffin-embedded (FFPE), algorithm reported as gene pathway activity score	Prior authorization is required.		
0264U	Rare diseases (constitutional/heritable disorders), identification of copy number variations, inversions, insertions, translocations and other structural variants by optical genome mapping	Prior authorization is required.		
0265U	Rare constitutional and other heritable disorders, whole genome and mitochondrial DNA sequence analysis, blood, frozen and formalin-fixed paraffin-embedded (FFPE) tissue, saliva, buccal swabs or cell lines, identification of single nucleotide and copy number variants	Prior authorization is required.		
0266U	Unexplained constitutional or other heritable disorders or syndromes, tissue-specific gene expression by whole-transcriptome and next-generation sequencing, blood, formalin-fixed paraffin-embedded (FFPE) tissue or fresh frozen tissue, reported as presence or absence of splicing or expression changes	Prior authorization is required.		
0267U	Rare constitutional and other heritable disorders, identification of copy number variations, inversions, insertions, translocations and other structural variants by optical genome mapping and whole genome sequencing	Prior authorization is required.		
0268U	Hematology (atypical hemolytic uremic syndrome [aHUS]), genomic sequence analysis of 15 genes, blood, buccal swab, or amniotic fluid	Prior authorization is required.		
0269U	Hematology (autosomal dominant congenital thrombocytopenia), genomic sequence analysis of 14 genes, blood, buccal swab, or amniotic fluid	Prior authorization is required.		

0270U	Hematology (congenital coagulation disorders), genomic sequence analysis of 20 genes, blood, buccal swab, or amniotic fluid	Prior authorization is required.		
0271U	Hematology (congenital neutropenia), genomic sequence analysis of 23 genes, blood, buccal swab, or amniotic fluid	Prior authorization is required.		
0272U	Hematology (genetic bleeding disorders), genomic sequence analysis of 51 genes, blood, buccal swab, or amniotic fluid, comprehensive	Prior authorization is required.		
0273U	Hematology (genetic hyperfibrinolysis, delayed bleeding), analysis of 9 genes (F13A1, F13B, FGA, FGB, FGG, SERPINA1, SERPINE1, SERPINF2 by next-generation sequencing and PLAU by array comparative genomic hybridization), blood, buccal swab, or amniotic fluid	Prior authorization is required.		
0274T	Percutaneous laminotomy/laminectomy (interlaminar approach) for decompression of neural elements, (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy), any method, under indirect image guidance (e.g., fluoroscopic, CT), single or multiple levels, unilateral or bilateral; cervical or thoracic	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
0274U	Hematology (genetic platelet disorders), genomic sequence analysis of 43 genes, blood, buccal swab, or amniotic fluid	Prior authorization is required.		
0275T	Percutaneous laminotomy/laminectomy (interlaminar approach) for decompression of neural elements, (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy), any method, under indirect image guidance (e.g., fluoroscopic, CT), single or multiple levels, unilateral or bilateral; lumbar	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
0276U	Hematology (inherited thrombocytopenia), genomic sequence analysis of 42 genes, blood, buccal swab, or amniotic fluid	Prior authorization is required.		
0277U	Hematology (genetic platelet function disorder), genomic sequence analysis of 31 genes, blood, buccal swab, or amniotic fluid	Prior authorization is required.		
0278U	Hematology (genetic thrombosis), genomic sequence analysis of 12 genes, blood, buccal swab, or amniotic fluid	Prior authorization is required.		
0282U	Red blood cell antigen typing, DNA, genotyping of 12 blood group system genes to predict 44 red blood cell antigen phenotypes	Prior authorization is required.		
0285U	Oncology, response to radiation, cell-free DNA, quantitative branched chain DNA amplification, plasma, reported as a radiation toxicity score	Prior authorization is required.		
0286U	CEP72 (centrosomal protein, 72-KDa), NUDT15 (nudix hydrolase 15) and TPMT (thiopurine S-methyltransferase) (eg, drug metabolism) gene analysis, common variants	Prior authorization is required.		
0287U	Oncology (thyroid), DNA and mRNA, next-generation sequencing analysis of 112 genes, fine needle aspirate or formalin-fixed paraffin-embedded (FFPE) tissue, algorithmic prediction of cancer recurrence, reported as a categorical risk result (low, intermediate, high)	Prior authorization is required.		
0288U	Oncology (lung), mRNA, quantitative PCR analysis of 11 genes (BAG1, BRCA1, CDC6, CDK2AP1, ERBB3, FUT3, IL11, LCK, RND3, SH3BGR, WNT3A) and 3 reference genes (ESD, TBP, YAP1), formalin-fixed paraffin-embedded (FFPE) tumor tissue, algorithmic interpretation reported as a recurrence risk score	Prior authorization is required.		
0289U	Neurology (Alzheimer disease), mRNA, gene expression profiling by RNA sequencing of 24 genes, whole blood, algorithm reported as predictive risk score	Prior authorization is required.		
0290U	Pain management, mRNA, gene expression profiling by RNA sequencing of 36 genes, whole blood, algorithm reported as predictive risk score	Prior authorization is required.		
0291U	Psychiatry (mood disorders), mRNA, gene expression profiling by RNA sequencing of 144 genes, whole blood, algorithm reported as predictive risk score	Prior authorization is required.		
0292U	Psychiatry (stress disorders), mRNA, gene expression profiling by RNA sequencing of 72 genes, whole blood, algorithm reported as predictive risk score	Prior authorization is required.		
0293U	Psychiatry (suicidal ideation), mRNA, gene expression profiling by RNA sequencing of 54 genes, whole blood, algorithm reported as predictive risk score	Prior authorization is required.		
0294U	Longevity and mortality risk, mRNA, gene expression profiling by RNA sequencing of 18 genes, whole blood, algorithm reported as predictive risk score	Prior authorization is required.		
0296U	Oncology (oral and/or oropharyngeal cancer), gene expression profiling by RNA sequencing of at least 20 molecular features (eg, human and/or microbial mRNA), saliva, algorithm reported as positive or negative for signature associated with malignancy	Prior authorization is required.		
0297U	Oncology (pan tumor), whole genome sequencing of paired malignant and normal DNA specimens, fresh or formalin-fixed paraffin-embedded (FFPE) tissue, blood or bone marrow, comparative sequence analyses and variant identification	Prior authorization is required.		
0298U	Oncology (pan tumor), whole transcriptome sequencing of paired malignant and normal RNA specimens, fresh or formalin-fixed paraffin-embedded (FFPE) tissue, blood or bone marrow, comparative sequence analyses and expression level and chimeric transcript identification	Prior authorization is required.		
0299U	Oncology (pan tumor), whole genome optical genome mapping of paired malignant and normal DNA specimens, fresh frozen tissue, blood, or bone marrow, comparative structural variant identification	Prior authorization is required.		
0300U	Oncology (pan tumor), whole genome sequencing and optical genome mapping of paired malignant and normal DNA specimens, fresh tissue, blood, or bone marrow, comparative sequence analyses and variant identification	Prior authorization is required.		
0301U	Infectious agent detection by nucleic acid (DNA or RNA), Bartonella henselae and Bartonella quintana, droplet digital PCR (ddPCR);	Prior authorization is required.		

0302U	Infectious agent detection by nucleic acid (DNA or RNA), Bartonella henselae and Bartonella quintana, droplet digital PCR (ddPCR); following liquid enrichment	Prior authorization is required.		
0312T	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	Prior authorization is required.		
0313T	Vagus nerve blocking therapy (morbid obesity); laparoscopic revision or replacement of vagal trunk neurostimulator electrode array, including connection to existing pulse generator	Prior authorization is required.		
0313U	Oncology (pancreas), DNA and mRNA next-generation sequencing analysis of 74 genes and analysis of CEA (CEACAM5) gene expression, pancreatic cyst fluid, algorithm reported as a categorical result (ie, negative, low probability of neoplasia or positive, high probability of neoplasia)	Prior authorization is required.		
0314T	Vagus nerve blocking therapy (morbid obesity); laparoscopic removal of vagal trunk neurostimulator electrode array and pulse generator	Prior authorization is required.		
0314U	Oncology (cutaneous melanoma), mRNA gene expression profiling by RT-PCR of 35 genes (32 content and 3 housekeeping), utilizing formalin-fixed paraffin-embedded (FFPE) tissue, algorithm reported as a categorical result (ie, benign, intermediate, malignant)	Prior authorization is required.		
0315T	Vagus nerve blocking therapy (morbid obesity); removal of pulse generator	Prior authorization is required.		
0315U	Oncology (cutaneous squamous cell carcinoma), mRNA gene expression profiling by RT-PCR of 40 genes (34 content and 6 housekeeping), utilizing formalin-fixed paraffin-embedded (FFPE) tissue, algorithm reported as a categorical risk result (ie, Class 1, Class 2A, Class 2B)	Prior authorization is required.		
0316T	Vagus nerve blocking therapy (morbid obesity); replacement of pulse generator	Prior authorization is required.		
0317T	Vagus nerve blocking therapy (morbid obesity); neurostimulator pulse generator electronic analysis, includes reprogramming when performed	Prior authorization is required.		
0331T	Myocardial sympathetic innervation imaging, planar qualitative and quantitative assessment;	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
0332T	Myocardial sympathetic innervation imaging, planar qualitative and quantitative assessment; with tomographic SPECT	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
0332U	Oncology (pan-tumor), genetic profiling of 8 DNA-regulatory (epigenetic) markers by quantitative polymerase chain reaction (qPCR), whole blood, reported as a high or low probability of responding to immune checkpoint–inhibitor therapy	Prior authorization is required.		
0333U	Oncology (liver), surveillance for hepatocellular carcinoma (HCC) in high-risk patients, analysis of methylation patterns on circulating cell-free DNA (cfDNA) plus measurement of serum of AFP/AFP-L3 and oncoprotein des-gamma-carboxy-prothrombin (DCP), algorithm reported as normal or abnormal result	Prior authorization is required.		
0335U	Rare diseases (constitutional/heritable disorders), whole genome sequence analysis, including small sequence changes, copy number variants, deletions, duplications, mobile element insertions, uniparental disomy (UPD), inversions, aneuploidy, mitochondrial genome sequence analysis with heteroplasmy and large deletions, short tandem repeat (STR) gene expansions, fetal sample, identification and categorization of genetic variants	Prior authorization is required.		
0336U	Rare diseases (constitutional/heritable disorders), whole genome sequence analysis, including small sequence changes, copy number variants, deletions, duplications, mobile element insertions, uniparental disomy (UPD), inversions, aneuploidy, mitochondrial genome sequence analysis with heteroplasmy and large deletions, short tandem repeat (STR) gene expansions, blood or saliva, identification and categorization of genetic variants, each comparator genome (eg, parent)	Prior authorization is required.		
0340U	Oncology (pan-cancer), analysis of minimal residual disease (MRD) from plasma, with assays personalized to each patient based on prior next-generation sequencing of the patient's tumor and germline DNA, reported as absence or presence of MRD, with disease-burden correlation, if appropriate	Prior authorization is required.		
0341U	Fetal aneuploidy DNA sequencing comparative analysis, fetal DNA from products of conception, reported as normal (euploidy), monosomy, trisomy, or partial deletion/duplication, mosaicism and segmental aneuploid	Prior authorization is required.		
0402T	Collagen cross-linking of cornea, including removal of the corneal epithelium, when performed and intraoperative pachymetry, when performed	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1099 Corneal Surgery to Correct Refractive Errors, Phototherapeutic Keratectomy and Corneal Collagen Cross-Linking Surgery	
0439T	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)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
0515T	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])	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
0516T	Insertion of wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming and imaging supervision and interpretation, when performed; electrode only	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
0517T	Insertion of wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming, and imaging supervision and interpretation, when performed; both components of pulse generator (battery and transmitter) only	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.

0519T	Removal and replacement of pulse generator for wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming; both components (battery and transmitter)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
0520T	Removal and replacement of pulse generator for wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming; battery component only	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
0524T	Endovenous catheter directed chemical ablation with balloon isolation of incompetent extremity vein, open or percutaneous, including all vascular access, catheter manipulation, diagnostic imaging, imaging guidance and monitoring	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1100 Surgical Treatment of Varicose Veins	
0571T	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	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
0572T	Insertion of substernal implantable defibrillator electrode	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
0609T*	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	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
0610T*	Magnetic resonance spectroscopy, determination and localization of discogenic pain (cervical, thoracic, or lumbar); transmission of biomarker data for software analysis	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
0611T*	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	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
0612T*	Magnetic resonance spectroscopy, determination and localization of discogenic pain (cervical, thoracic, or lumbar); interpretation and report	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
0614T*	Removal and replacement of substernal implantable defibrillator pulse generator	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
0623T	Automated quantification and characterization of coronary atherosclerotic plaque to assess severity of coronary disease, using data from coronary computed tomographic angiography; data preparation and transmission, computerized analysis of data, with review of computerized analysis output to reconcile discordant data, interpretation and report	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
0624T	Automated quantification and characterization of coronary atherosclerotic plaque to assess severity of coronary disease, using data from coronary computed tomographic angiography; data preparation and transmission	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
0625T	Automated quantification and characterization of coronary atherosclerotic plaque to assess severity of coronary disease, using data from coronary computed tomographic angiography; computerized analysis of data from coronary computed tomographic angiography	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
0626T	Automated quantification and characterization of coronary atherosclerotic plaque to assess severity of coronary disease, using data from coronary computed tomographic angiography; review of computerized analysis output to reconcile discordant data, interpretation and report	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
0627T	Percutaneous injection of allogeneic cellular and/or tissue- based product, intervertebral disc, unilateral or bilateral injection, with fluoroscopic guidance, lumbar; first level	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
0628T	Percutaneous injection of allogeneic cellular and/or tissue- based product, intervertebral disc, unilateral or bilateral injection, with fluoroscopic guidance, lumbar; each additional level (List separately in addition to code for primary procedure)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
0629T	Percutaneous injection of allogeneic cellular and/or tissue- based product, intervertebral disc, unilateral or bilateral injection, with CT guidance, lumbar; first level	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
0630T	Percutaneous injection of allogeneic cellular and/or tissue- based product, intervertebral disc, unilateral or bilateral injection, with CT guidance, lumbar; each additional level (List separately in addition to code for primary procedure)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
0633T*	Computed tomography, breast, including 3D rendering, when performed, unilateral; without contrast material	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
0634T*	Computed tomography, breast, including 3D rendering, when performed, unilateral; with contrast material(s)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
0635T*	Computed tomography, breast, including 3D rendering, when performed, unilateral; without contrast, followed by contrast material(s)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
0636T*	Computed tomography, breast, including 3D rendering, when performed, bilateral; without contrast material(s)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
0637T*	Computed tomography, breast, including 3D rendering, when performed, bilateral; with contrast material(s)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
0638T*	Computed tomography, breast, including 3D rendering, when performed, bilateral; without contrast, followed by contrast material(s)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.

0648T	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.	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
0649T	Quantitative magnetic resonance for analysis of tissue composition (eg, fat, iron, water content), including multiparametric data acquisition, data preparation and transmission, interpretation and report, obtained without diagnostic MRI examination of the same anatomy (eg, organ, gland, tissue, target structure) during the same session; single organ	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
0697T	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)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
0698T	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)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
0710T	Noninvasive arterial plaque analysis using software processing of data from non-coronary computerized tomography angiography; including data preparation and transmission, quantification of the structure and composition of the vessel wall and assessment for lipid-rich necrotic core plaque to assess atherosclerotic plaque stability, data review, interpretation and report	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
0711T	Noninvasive arterial plaque analysis using software processing of data from non-coronary computerized tomography angiography; data preparation and transmission	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
0712T	Noninvasive arterial plaque analysis using software processing of data from non-coronary computerized tomography angiography; quantification of the structure and composition of the vessel wall and assessment for lipid-rich necrotic core plaque to assess atherosclerotic plaque stability	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
0713T	Noninvasive arterial plaque analysis using software processing of data from non-coronary computerized tomography angiography; data review, interpretation and report	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
0742T	Absolute quantitation of myocardial blood flow (AQMBF), single-photon emission computed tomography (SPECT), with exercise or pharmacologic stress, and at rest, when performed (List separately in addition to code for primary procedure)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
0784T	Insertion or replacement of percutaneous electrode array, spinal, with integrated neurostimulator, including imaging guidance, when performed	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
0785T	Revision or removal of neurostimulator electrode array, spinal, with integrated neurostimulator	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
0797T	Transcatheter insertion of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (eg, interrogation or programming), when performed; right ventricular pacemaker component (when part of a dual-chamber leadless pacemaker system)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
0798T	Transcatheter removal of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography), when performed; complete system (ie, right atrial and right ventricular pacemaker components)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
0799T	Transcatheter removal of right atrial pacemaker component	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
0800T	Transcatheter removal of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography), when performed; right ventricular pacemaker component (when part of a dual-chamber leadless pacemaker system)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
0801T	Transcatheter removal and replacement of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (eg, interrogation or programming), when performed; dual-chamber system (ie, right atrial and right ventricular pacemaker components)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
0802T	Transcatheter removal and replacement of right atrial pacemaker component	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
0803T	Transcatheter removal and replacement of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (eg, interrogation or programming), when performed; right ventricular pacemaker component (when part of a dual-chamber leadless pacemaker system)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
0865T	Quantitative magnetic resonance image (MRI) analysis of the brain with comparison to prior magnetic resonance (MR) study(ies), including lesion identification, characterization, and quantification, with brain volume(s) quantification and/or severity score, when performed, data preparation and transmission, interpretation and report, obtained without diagnostic MRI examination of the brain during the same session	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.

0866T	Quantitative magnetic resonance image (MRI) analysis of the brain with comparison to prior magnetic resonance (MR) study(ies), including lesion detection, characterization, and quantification, with brain volume(s) quantification and/or severity score, when performed, data preparation and transmission, interpretation and report, obtained with diagnostic MRI examination of the brain (List separately in addition to code for primary procedure)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
A0090	Nonemergency transportation, per mile - vehicle provided by individual (family member, self, neighbor) with vested interest	Reference policies for additional information. the DMMA Provider Portal https://medicaid.dhss.delaware.gov		
A0100	Nonemergency transportation; taxi	Reference policies for additional information. the DMMA Provider Portal. https://medicaid.dhss.delaware.gov		
A0110	Nonemergency transportation and bus, intra- or interstate carrier	Reference policies for additional information. the DMMA Provider Portal. https://medicaid.dhss.delaware.gov		
A0120	Nonemergency transportation: mini-bus, mountain area transports, or other transportation systems	Reference policies for additional information. the DMMA Provider Portal. https://medicaid.dhss.delaware.gov		
A0130	Nonemergency transportation: wheelchair van	Reference policies for additional information. the DMMA Provider Portal. https://medicaid.dhss.delaware.gov		
A0160	Nonemergency transportation: per mile - caseworker or social worker	Reference policies for additional information. the DMMA Provider Portal. https://medicaid.dhss.delaware.gov		
A0426	Ambulance service, advanced life support, nonemergency transport, level 1 (ALS 1)	Reference policies for additional information. the DMMA Provider Portal. https://medicaid.dhss.delaware.gov		
A0428	Ambulance service, basic life support, nonemergency transport, (BLS)	Reference policies for additional information. the DMMA Provider Portal. https://medicaid.dhss.delaware.gov		
A4100	Skin substitute, fda cleared as a device, not otherwise specified	Prior authorization is required for billed charges greater than $500.		
A4206	SYRINGE W/NEEDLE STERIL 1 CC/< EACH	Prior authorization is required when the billed charges are greater than $500.		
A4207	SYRINGE W/NEEDLE STERILE 2 CC EACH	Prior authorization is required when the billed charges are greater than $500.		
A4208	SYRINGE W/NEEDLE STERILE 3 CC EACH	Prior authorization is required when the billed charges are greater than $500.		
A4209	SYRINGE W/NEEDLE STERILE 5 CC/> EA	Prior authorization is required when the billed charges are greater than $500.		
A4210	NEEDLE-FREE INJECTION DEVICE EACH	Prior authorization is required when the billed charges are greater than $500.		
A4211	SUPPLIES SELF-ADMINED INJECTIONS	Prior authorization is required when the billed charges are greater than $500.		
A4212	NONCORING NEEDLE/STYLET W/WO CATH	Prior authorization is required when the billed charges are greater than $500.		
A4213	SYRINGE STERILE 20 CC/GREATER EACH	Prior authorization is required when the billed charges are greater than $500.		
A4215	NEEDLE STERILE ANY SIZE EACH	Prior authorization is required when the billed charges are greater than $500.		
A4216	STERL H2O SALINE & OR DXT DIL 10 ML	Prior authorization is required when the billed charges are greater than $500.		
A4217	STERILE WATER/SALINE 500 ML	Prior authorization is required when the billed charges are greater than $500.		
A4218	STERL SALINE/WATR METRD DOSE 10 ML	Prior authorization is required when the billed charges are greater than $500.		
A4220	REFILL KIT IMPLANTABLE INFUS PUMP	Prior authorization is required when the billed charges are greater than $500.		
A4221	Supplies for maintenance of noninsulin drug infusion catheter, per week (list drugs separately)	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1134 Portable External Infusion Pump	
A4222	Infusion supplies for external drug infusion pump, per cassette or bag (list drugs separately)	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1134 Portable External Infusion Pump	
A4223	INFUS SPL NO EXT INFUS PUMP CAS/BAG	Prior authorization is required when the billed charges are greater than $500.		
A4224	SPL MAINT INSULIN INFUS CATH PER WK	Prior authorization is required when the billed charges are greater than $500.		
A4225	SPL EXT INS INF PMP SYR T CART ST E	Prior authorization is required when the billed charges are greater than $500.		
A4226	S MNT INS IP DR ADJ TX CNT G SNS PW	Prior authorization is required when the billed charges are greater than $500.		
A4230	INFUS SET EXT INSULIN PUMP NONNDLE	Prior authorization is required when the billed charges are greater than $500.		
A4231	INFUS SET EXT INSULIN PUMP NEEDLE	Prior authorization is required when the billed charges are greater than $500.		
A4232	SYRINGE NDLE EXT INSULIN PUMP STERL	Prior authorization is required when the billed charges are greater than $500.		
A4233	REPL BATT ALK NOT J CELL HOM BG MON	Prior authorization is required when the billed charges are greater than $500.		
A4234	REPL BATT ALK J CELL HOM BG MON	Prior authorization is required when the billed charges are greater than $500.		
A4235	REPL BATT LITHIUM HOM BG MON OWN PT	Prior authorization is required when the billed charges are greater than $500.		
A4236	REPL BATT SILVER OXIDE HOM BG MON	Prior authorization is required when the billed charges are greater than $500.		
A4238	SPL ALW ADJ CGM S & ACC 1 M S=1 U S	Prior authorization is required when the billed charges are greater than $500.		
A4239	Supply allowance for non-adjunctive, non-implanted continuous glucose monitor (cgm), includes all supplies and accessories, 1 month supply = 1 unit of service	Prior authorization is required when the billed charges are greater than $500.		
A4244	ALCOHOL OR PEROXIDE PER PINT	Prior authorization is required when the billed charges are greater than $500.		
A4245	ALCOHOL WIPES PER BOX	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1246 Home Dialysis Equipment and Supplies	
A4246	BETADINE/PHISOHEX SOLUTION PER PINT	Prior authorization is required when the billed charges are greater than $500.		
A4247	BETADINE/IODINE SWABS/WIPES PER BOX	Prior authorization is required when the billed charges are greater than $500.		
A4248	CHLORHEXIDINE CONTAINING ANTISEPTIC	Prior authorization is required when the billed charges are greater than $500.		
A4250	URINE TEST/REAGENT STRIPS/TABLETS	Prior authorization is required when the billed charges are greater than $500.		
A4252	BLOOD KETONE TEST/REAGENT STRIP EA	Prior authorization is required when the billed charges are greater than $500.		
A4253	BLD GLU TST/REAGT STRIPS HOM MON-50	Prior authorization is required when the billed charges are greater than $500.		
A4255	PLATFORMS HOM BLD GLU MON 50-BOX	Prior authorization is required when the billed charges are greater than $500.		
A4256	NORMAL LOW&HI CALIBRATOR SOL/CHIPS	Prior authorization is required when the billed charges are greater than $500.		
A4257	REPL LENS SHIELD CARTRIDGE LASR SKN	Prior authorization is required when the billed charges are greater than $500.		
A4258	SPRING-POWERED DEVICE LANCET EACH	Prior authorization is required when the billed charges are greater than $500.		
A4259	LANCETS PER BOX OF 100	Prior authorization is required when the billed charges are greater than $500.		
A4262	TEMP ABSORB LAC DUCT IMPLANT EA	Prior authorization is required when the billed charges are greater than $500.		

A4263	PERM NONDISSOLV LAC DUCT IMPL EA	Prior authorization is required when the billed charges are greater than $500.		
A4264	PERM IMPL CONTRCPTV TUBAL OCCL DEV	Prior authorization is required when the billed charges are greater than $500.		
A4265	PARAFFIN PER POUND	Prior authorization is required when the billed charges are greater than $500.		
A4270	DISPOSABLE ENDOSCOPE SHEATH EACH	Prior authorization is required when the billed charges are greater than $500.		
A4280	Adhesive skin support attachment for use with external breast prosthesis, each	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1027 Breast Reconstructive Surgery	
A4281	TUBING FOR BREAST PUMP REPLACEMENT	Prior authorization is required when the billed charges are greater than $500.		
A4282	ADAPTER FOR BREAST PUMP REPLACEMENT	Prior authorization is required when the billed charges are greater than $500.		
A4283	CAP BREAST PUMP BOTTLE REPLACEMENT	Prior authorization is required when the billed charges are greater than $500.		
A4284	BRST SHIELD&SPLSH PROTCTR PUMP REPL	Prior authorization is required when the billed charges are greater than $500.		
A4285	POLYCARBATE BOTTLE BREAST PUMP REPL	Prior authorization is required when the billed charges are greater than $500.		
A4286	LOCKING RING BREAST PUMP REPLACMENT	Prior authorization is required when the billed charges are greater than $500.		
A4287	Disposable collection and storage bag for breast milk, any size, any type, each	Prior authorization is required when the billed charges are greater than $500.		
A4290	SACRAL NERVE STIM TEST LEAD EACH	Prior authorization is required when the billed charges are greater than $500.		
A4300	IMPL ACSS CATHETER EXTERNAL ACCESS	Prior authorization is required when the billed charges are greater than $500.		
A4301	IMPL ACSS TOTAL CATH PORT/RESERVOIR	Prior authorization is required when the billed charges are greater than $500.		
A4305	DISPBL RX DEL SYS RATE 50 ML/>-HR	Prior authorization is required when the billed charges are greater than $500.		
A4306	DISPOSABL RX DEL SYS FLW < 50 ML HR	Prior authorization is required when the billed charges are greater than $500.		
A4310	INSRTION TRAY W/O DRN BAG&W/O CATH	Prior authorization is required when the billed charges are greater than $500.		
A4311	INSRTION TRAY W/O BAG 2-WAY LATEX	Prior authorization is required when the billed charges are greater than $500.		
A4312	INSRTION TRAY W/O BAG 2-WAY SILCON	Prior authorization is required when the billed charges are greater than $500.		
A4313	INSRT TRAY W/O BAG 3-WAY CNT IRRIG	Prior authorization is required when the billed charges are greater than $500.		
A4314	INSRTION TRAY W/BAG 2-WAY LATEX	Prior authorization is required when the billed charges are greater than $500.		
A4315	INSRTION TRAY W/BAG 2-WAY SILCON	Prior authorization is required when the billed charges are greater than $500.		
A4316	INSRTION TRAY W/BAG 3-WAY CONT IRRG	Prior authorization is required when the billed charges are greater than $500.		
A4320	IRRIG TRAY W/BULB/PISTON SYRINGE	Prior authorization is required when the billed charges are greater than $500.		
A4321	THERAPEUTIC AGT URIN CATH IRRIG	Prior authorization is required when the billed charges are greater than $500.		
A4322	IRRIGATION SYRINGE BULB/PISTON EACH	Prior authorization is required when the billed charges are greater than $500.		
A4326	MALE EXT CATH CLCT CHAMB ANY TYPE	Prior authorization is required when the billed charges are greater than $500.		
A4327	FE EXT URIN CLCT DEVC; METL CUP EA	Prior authorization is required when the billed charges are greater than $500.		
A4328	FE EXT URIN CLCT DEVICE; POUCH EA	Prior authorization is required when the billed charges are greater than $500.		
A4330	Perianal fecal collection pouch with adhesive, each	Prior authorization is required if more than 8 units are billed per day.		
A4331	EXT DRN TUBING W/CNCTOR/ADAPTR EA	Prior authorization is required when the billed charges are greater than $500.		
A4332	LUBRICNT INDIVIDUAL STERL PACKET EA	Prior authorization is required when the billed charges are greater than $500.		
A4333	URIN CATH ANCHR DEVC ADHES ATTCH EA	Prior authorization is required when the billed charges are greater than $500.		
A4334	URIN CATH ANCHR DEVICE LEG STRAP EA	Prior authorization is required when the billed charges are greater than $500.		
A4335	Incontinence supply; miscellaneous	Prior authorization is required for billed charges greater than $500.		
A4336	INCONT SUPPLY URETHRAL INSERT EA	Prior authorization is required when the billed charges are greater than $500.		
A4337	INCONT SPL RECTAL INSRT ANY TYPE EA	Prior authorization is required when the billed charges are greater than $500.		
A4338	INDWLL CATH; 2-WAY LATEX W/COAT EA	Prior authorization is required when the billed charges are greater than $500.		
A4340	INDWELL CATHETER; SPECIALTY TYPE EA	Prior authorization is required when the billed charges are greater than $500.		
A4344	INDWLL CATH FOLEY 2-WAY SILCON EA	Prior authorization is required when the billed charges are greater than $500.		
A4346	INDWLL CATH; FOLY 3-WAY CONT IRRIG	Prior authorization is required when the billed charges are greater than $500.		
A4349	MALE EXT CATH W/WO ADHES DISPBL EA	Prior authorization is required when the billed charges are greater than $500.		
A4351	INTERMIT URIN CATH; STRAIT TIP EA	Prior authorization is required when the billed charges are greater than $500.		
A4352	INTERMIT URIN CATH; COUDE TIP EA	Prior authorization is required when the billed charges are greater than $500.		
A4353	INTERMIT URIN CATH W/INSERTION SPL	Prior authorization is required when the billed charges are greater than $500.		
A4354	INSRTION TRAY W/DRN BAG W/O CATH	Prior authorization is required when the billed charges are greater than $500.		
A4355	IRRIG TUBING CONT 3-WAY CATH EA	Prior authorization is required when the billed charges are greater than $500.		
A4356	EXT URETHRAL CLAMP/COMPRS DEVICE EA	Prior authorization is required when the billed charges are greater than $500.		
A4357	BEDSID DRN BAG DAY/NGT W/WO TUBE EA	Prior authorization is required when the billed charges are greater than $500.		
A4358	URINARY LEG BAG; VINYL W/WO TUBE EA	Prior authorization is required when the billed charges are greater than $500.		
A4360	DISP EXT URETHRAL CLAMP/COMP DEV EA	Prior authorization is required when the billed charges are greater than $500.		
A4361	OSTOMY FACEPLATE EACH	Prior authorization is required when the billed charges are greater than $500.		
A4362	SKN BARRIER; SOLID 4X4/EQUVALNT; EA	Prior authorization is required when the billed charges are greater than $500.		
A4363	OSTOMY CLAMP ANY TYPE REPL ONLY EA	Prior authorization is required when the billed charges are greater than $500.		
A4364	ADHES LIQUID/EQUAL ANY TYPE-OUNCE	Prior authorization is required when the billed charges are greater than $500.		
A4366	OSTOMY VENT ANY TYPE EACH	Prior authorization is required when the billed charges are greater than $500.		
A4367	OSTOMY BELT EACH	Prior authorization is required when the billed charges are greater than $500.		
A4368	OSTOMY FILTER ANY TYPE EACH	Prior authorization is required when the billed charges are greater than $500.		
A4369	OSTOMY SKIN BARRIER LIQUID PER OZ	Prior authorization is required when the billed charges are greater than $500.		
A4371	OSTOMY SKIN BARRIER POWDER PER OZ	Prior authorization is required when the billed charges are greater than $500.		
A4372	OST SKIN BARR SOL 4X4/EQUV STD EA	Prior authorization is required when the billed charges are greater than $500.		
A4373	OST SKN BARR W/FLNGE BUILT-IN CONVX	Prior authorization is required when the billed charges are greater than $500.		
A4375	OST POUCH DRNABLE W/FCEPLAT PLST EA	Prior authorization is required when the billed charges are greater than $500.		
A4376	OST POUCH DRNABLE W/FCEPLAT RUBR EA	Prior authorization is required when the billed charges are greater than $500.		
A4377	OST POUCH DRNABLE FCEPLAT PLSTC EA	Prior authorization is required when the billed charges are greater than $500.		
A4378	OST POUCH DRAINABLE FCEPLAT RUBR EA	Prior authorization is required when the billed charges are greater than $500.		

A4379	OST POUCH URIN W/FCEPLAT PLSTC EA	Prior authorization is required when the billed charges are greater than $500.		
A4380	OST POUCH URIN W/FCEPLAT RUBR EA	Prior authorization is required when the billed charges are greater than $500.		
A4381	OST POUCH URIN USE FCEPLAT PLSTC EA	Prior authorization is required when the billed charges are greater than $500.		
A4382	OST POUCH URIN FCEPLAT HVY PLSTC EA	Prior authorization is required when the billed charges are greater than $500.		
A4383	OST POUCH URIN USE FCEPLAT RUBR EA	Prior authorization is required when the billed charges are greater than $500.		
A4384	OST FCEPLAT EQUVALNT SILCON RING EA	Prior authorization is required when the billed charges are greater than $500.		
A4385	OST SKN BARRIER 4X4 EXT W/O CONVXTY	Prior authorization is required when the billed charges are greater than $500.		
A4387	OST POUCH CLOS BARR BUILT-IN CONVX	Prior authorization is required when the billed charges are greater than $500.		
A4388	OST POUCH DRNABL W/EXT WEAR BARR EA	Prior authorization is required when the billed charges are greater than $500.		
A4389	OST POUCH DRNBL BARR BUILT-IN CONVX	Prior authorization is required when the billed charges are greater than $500.		
A4390	OST POUCH DRNABLE EXT W/CONVXITY EA	Prior authorization is required when the billed charges are greater than $500.		
A4391	OST POUCH URIN W/EXT WEAR BARR EA	Prior authorization is required when the billed charges are greater than $500.		
A4392	OST POUCH URIN STD W/CONVXITY EA	Prior authorization is required when the billed charges are greater than $500.		
A4393	OST POUCH URIN EXT W/CONVXITY EA	Prior authorization is required when the billed charges are greater than $500.		
A4394	OSTOMY DEODORANT W/WO LUB PER FL OZ	Prior authorization is required when the billed charges are greater than $500.		
A4395	OST DEODORANT OST POUCH SOLID-TAB	Prior authorization is required when the billed charges are greater than $500.		
A4396	OSTOMY BELT W/PERISTOMAL HERN SUP	Prior authorization is required when the billed charges are greater than $500.		
A4397	IRRIGATION SUPPLY; SLEEVE EACH	Prior authorization is required when the billed charges are greater than $500.		
A4398	OSTOMY IRRIGATION SUPPLY; BAG EACH	Prior authorization is required when the billed charges are greater than $500.		
A4399	OST IRRIG SPL; CONE/CATH W/WO BRUSH	Prior authorization is required when the billed charges are greater than $500.		
A4400	OSTOMY IRRIGATION SET	Prior authorization is required when the billed charges are greater than $500.		
A4402	LUBRICANT PER OUNCE	Prior authorization is required when the billed charges are greater than $500.		
A4404	OSTOMY RING EACH	Prior authorization is required when the billed charges are greater than $500.		
A4405	OST SKN BARRIER NONPECTIN PASTE-OZ	Prior authorization is required when the billed charges are greater than $500.		
A4406	OST SKN BARRIER PECTIN PASTE-OZ	Prior authorization is required when the billed charges are greater than $500.		
A4407	OST SKN BARRIER W/CONVXITY 4X4 IN/<	Prior authorization is required when the billed charges are greater than $500.		
A4408	OST SKN BARRIER W/CONVXITY > 4X4 IN	Prior authorization is required when the billed charges are greater than $500.		
A4409	OST SKN BARR EXT W/O CONVX 4X4 IN/<	Prior authorization is required when the billed charges are greater than $500.		
A4410	OST SKN BARR EXT W/O CONVX >4X4 IN	Prior authorization is required when the billed charges are greater than $500.		
A4411	OST SKN BARR SOLID 4X4/EQ W/CONVXTY	Prior authorization is required when the billed charges are greater than $500.		
A4412	OST POUCH DRNBL BARR FLNGE W/O FLTR	Prior authorization is required when the billed charges are greater than $500.		
A4413	OST POUCH DRNABL BARRIER FLNGE/FLTR	Prior authorization is required when the billed charges are greater than $500.		
A4414	OST SKN BARRIER W/O CONVX 4X4 IN/<	Prior authorization is required when the billed charges are greater than $500.		
A4415	OST SKN BARRIER W/O CONVX >4X4 IN	Prior authorization is required when the billed charges are greater than $500.		
A4416	OST POUCH CLO BARR ATTCH W/FILTR EA	Prior authorization is required when the billed charges are greater than $500.		
A4417	OST POUCH CLO BARR W/BLT-IN CONVXIT	Prior authorization is required when the billed charges are greater than $500.		
A4418	OST POUCH CLOS; W/O BARR W/FILTR EA	Prior authorization is required when the billed charges are greater than $500.		
A4419	OST POUCH CLOS; BARRIER W/NON-LOCK	Prior authorization is required when the billed charges are greater than $500.		
A4420	OST POUCH CLO;USE BARR LOCK FLNG EA	Prior authorization is required when the billed charges are greater than $500.		
A4421	Ostomy supply; miscellaneous	Prior authorization is required for billed charges greater than $500.		
A4422	OST ABSORB MATL THICKN LQD STOML OP	Prior authorization is required when the billed charges are greater than $500.		
A4423	OST POUCH CLOS; BARR W/LOCK FLNG EA	Prior authorization is required when the billed charges are greater than $500.		
A4424	OST POUCH DRNBL BARR ATTCH FILTR EA	Prior authorization is required when the billed charges are greater than $500.		
A4425	OST POUCH DRNBL; BARR NON-LOCK FLNG	Prior authorization is required when the billed charges are greater than $500.		
A4426	OST POUCH DRNBL;BARR W/LOCK FLNG EA	Prior authorization is required when the billed charges are greater than $500.		
A4427	OST POUCH DRN;BARR LOCK FLNG FLTR	Prior authorization is required when the billed charges are greater than $500.		
A4428	OST POUCH URIN W/FAUCET TAP W/VALVE	Prior authorization is required when the billed charges are greater than $500.		
A4429	OST POUCH URIN W/BLT-IN CONVX VALVE	Prior authorization is required when the billed charges are greater than $500.		
A4430	OST POUCH URN BLT-IN CNVX FAUCT VLV	Prior authorization is required when the billed charges are greater than $500.		
A4431	OST POUCH URIN;BARR FAUCT TAP VLV	Prior authorization is required when the billed charges are greater than $500.		
A4432	OST POUCH URN;NO-LCK FLNG FAUCT VLV	Prior authorization is required when the billed charges are greater than $500.		
A4433	OST POUCH URIN; BARR W/LOCK FLNG EA	Prior authorization is required when the billed charges are greater than $500.		
A4434	OST POUCH URN;LOCK FLNG FAUCT VLV	Prior authorization is required when the billed charges are greater than $500.		
A4435	OST POUCH DRN HI OP EXT WR BARR EA	Prior authorization is required when the billed charges are greater than $500.		
A4436	IRRIGATION SUPPLY SLV REUSE PER MTH	Prior authorization is required when the billed charges are greater than $500.		
A4437	IRRIGATION SUPPLY SLV DISP PER MNTH	Prior authorization is required when the billed charges are greater than $500.		
A4450	TAPE NON-WATERPROOF 18 SQUARE IN	Prior authorization is required when the billed charges are greater than $500.		
A4452	TAPE WATERPROOF PER 18 SQUARE IN	Prior authorization is required when the billed charges are greater than $500.		
A4455	ADHESIVE REMOVER/SOLVENT PER OUNCE	Prior authorization is required when the billed charges are greater than $500.		
A4456	ADHESIVE REMOVER WIPES ANY TYPE EA	Prior authorization is required when the billed charges are greater than $500.		
A4457	Enema tube, with or without adapter, any type, replacement only, each	Prior authorization is required if more than 8 units are billed per day.		
A4458	Enema bag with tubing, reusable	Prior authorization is required if more than 8 units are billed per day.		
A4459	Manual pump-operated enema system, includes balloon, catheter and all accessories, reusable, any type	Prior authorization is required if more than 8 units are billed per day.		
A4461	SURG DRESSING HOLDR NON-REUSABLE EA	Prior authorization is required when the billed charges are greater than $500.		
A4463	SURG DRESSING HOLDER REUSABLE EA	Prior authorization is required when the billed charges are greater than $500.		
A4465	NONELASTIC BINDER FOR EXTREMITY	Prior authorization is required when the billed charges are greater than $500.		
A4467	BELT STRAP SLV GARMENT/COV ANY TYPE	Prior authorization is required when the billed charges are greater than $500.		

A4470	GRAVLEE JET WASHER	Prior authorization is required when the billed charges are greater than $500.		
A4480	VABRA ASPIRATOR	Prior authorization is required when the billed charges are greater than $500.		
A4481	TRACHEOSTOMA FLTR TYPE SZ EA	Prior authorization is required when the billed charges are greater than $500.		
A4483	MOISTR EXCHGR DISPBL W/INVASV VENT	Prior authorization is required when the billed charges are greater than $500.		
A4490	SURG STOCKING ABOVE KNEE LENGTH EA	Prior authorization is required when the billed charges are greater than $500.		
A4495	SURGICAL STOCKING THIGH LENGTH EACH	Prior authorization is required when the billed charges are greater than $500.		
A4500	SURG STOCKING BELOW KNEE LENGTH EA	Prior authorization is required when the billed charges are greater than $500.		
A4510	SURGICAL STOCKING FULL-LENGTH EACH	Prior authorization is required when the billed charges are greater than $500.		
A4520	INCONTINENCE GARMENT ANY TYPE EACH	Prior authorization is required when the billed charges are greater than $500.		
A4550	SURGICAL TRAYS	Prior authorization is required when the billed charges are greater than $500.		
A4553	Nondisposable underpads, all sizes	Prior authorization is required if more than 8 units are billed per day.		
A4554	Disposable underpads, all sizes	Prior authorization is required if more than 8 units are billed per day.		
A4555	E/TRANSDUCR E-STIM U CA TX RPL ONLY	Prior authorization is required when the billed charges are greater than $500.		
A4556	ELECTRODES PER PAIR	Prior authorization is required when the billed charges are greater than $500.		
A4557	LEAD WIRES PER PAIR	Prior authorization is required when the billed charges are greater than $500.		
A4558	CONDUCTVE GEL/PASTE USE W/ELEC DEVC	Prior authorization is required when the billed charges are greater than $500.		
A4559	Coupling gel or paste, for use with ultrasound device, per oz	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1251 Ultrasound Osteogenesis Stimulator	
A4561	PESSARY RUBBER ANY TYPE	Prior authorization is required when the billed charges are greater than $500.		
A4562	PESSARY NON RUBBER ANY TYPE	Prior authorization is required when the billed charges are greater than $500.		
A4563	RCTL CNTRL SYS VAG INSRT LT U ANY E	Prior authorization is required when the billed charges are greater than $500.		
A4565	SLINGS	Prior authorization is required when the billed charges are greater than $500.		
A4566	SHOULDR SLING/VEST ABD RSTRN PREFAB	Prior authorization is required when the billed charges are greater than $500.		
A4570	SPLINTS	Prior authorization is required when the billed charges are greater than $500.		
A4575	TOPICAL HYPRBR OXYGEN CHAMB DISPBL	Prior authorization is required when the billed charges are greater than $500.		
A4580	CAST SUPPLIES	Prior authorization is required when the billed charges are greater than $500.		
A4590	SPECIAL CASTING MATERIAL	Prior authorization is required when the billed charges are greater than $500.		
A4595	Electrical stimulator supplies, 2 lead, per month, (e.g., TENS, NMES)	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1185 Functional Neuromuscular Electrical Stimulation and Other Electrical Stimulator	
A4596	CES SYS SUP & ACCESSORIES PER MONTH	Prior authorization is required when the billed charges are greater than $500.		
A4600	SLEEVE INTERMITT LIMB COMP REPL EA	Prior authorization is required when the billed charges are greater than $500.		
A4601	LIB RECHARG NONPROSTHETIC USE REPL	Prior authorization is required when the billed charges are greater than $500.		
A4602	REPL BA EXT IP OWND PT LI 1.5 V EA	Prior authorization is required when the billed charges are greater than $500.		
A4604	Tubing with integrated heating element for use with positive airway pressure device	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1063 Devices Used for the Treatment of Obstructive Sleep Apnea in Adults and HHO-DE-MP-1076 Respiratory Assist Devices	
A4605	TRACHEAL SUCTION CATH CLOS SYS EA	Prior authorization is required when the billed charges are greater than $500.		
A4606	O2 PROBE W/OXIMETER DEVICE REPLCMT	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1072 Oxygen and HHO-DE-MP-1030 Home Oxygen Therapy	
A4608	TRANSTRACHEAL OXYGEN CATHETER EACH	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1072 Oxygen	
A4611	BATTRY HEVY DUTY; REPL PT-OWND VENT	Prior authorization is required when the billed charges are greater than $500.		
A4612	BATTRY CABLES; REPL PT-OWNED VENT	Prior authorization is required when the billed charges are greater than $500.		
A4613	BATTRY CHARGER; REPL PT-OWNED VENT	Prior authorization is required when the billed charges are greater than $500.		
A4614	PEAK EXPIRATORY FLW METER HAND HELD	Prior authorization is required when the billed charges are greater than $500.		
A4615	CANNULA NASAL	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1072 Oxygen	
A4616	TUBING PER FOOT	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1072 Oxygen	
A4617	MOUTHPIECE	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1072 Oxygen	
A4618	BREATHING CIRCUITS	Prior authorization is required when the billed charges are greater than $500.		
A4619	FACE TENT	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1072 Oxygen	
A4620	VARIABLE CONCENTRATION MASK	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1072 Oxygen	
A4623	TRACHEOSTOMY INNER CANNULA	Prior authorization is required when the billed charges are greater than $500.		
A4624	TRACHEAL SUCTN CATH NOT CLOS SYS EA	Prior authorization is required when the billed charges are greater than $500.		
A4625	TRACHEOST CARE KIT NEW TRACHEOST	Prior authorization is required when the billed charges are greater than $500.		
A4626	TRACHEOSTOMY CLEANING BRUSH EACH	Prior authorization is required when the billed charges are greater than $500.		
A4627	SPACR BAG/RESRVOR METRD DOSE INHAL	Prior authorization is required when the billed charges are greater than $500.		
A4628	OROPHARYNGEAL SUCTION CATHETER EACH	Prior authorization is required when the billed charges are greater than $500.		
A4629	TRACHEOST CARE KIT EST TRACHEOST	Prior authorization is required when the billed charges are greater than $500.		
A4630	REPL BATTRY TRNSQ ELEC STIM OWND PT	Prior authorization is required when the billed charges are greater than $500.		
A4633	REPLCMT BULB/LAMP UV LGHT TX SYS EA	Prior authorization is required when the billed charges are greater than $500.		
A4634	REPLCMT BULB TX LGHT BOX TABOP MDL	Prior authorization is required when the billed charges are greater than $500.		
A4635	UNDERARM PAD CRUTCH REPLACEMENT EA	Prior authorization is required when the billed charges are greater than $500.		
A4636	REPL HANDGRIP CANE CRTCH/WALKER EA	Prior authorization is required when the billed charges are greater than $500.		
A4637	REPL TIP CANE CRUTCH WALKER EA	Prior authorization is required when the billed charges are greater than $500.		

A4638	REPL BATT PT-OWND EAR PULSE GEN EA	Prior authorization is required when the billed charges are greater than $500.		
A4639	REPL PAD INFRARD HEATING PAD SYS EA	Prior authorization is required when the billed charges are greater than $500.		
A4640	Replacement pad for use with medically necessary alternating pressure pad owned by patient	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items	
A4649	Surgical supply; miscellaneous	Prior authorization is required for billed charges greater than $500.		
A4651	CALIBRATED MICROCAPILLARY TUBE EACH	Prior authorization is required when the billed charges are greater than $500.		
A4652	MICROCAPILLARY TUBE SEALANT	Prior authorization is required when the billed charges are greater than $500.		
A4653	PERITON DIALYSIS CATH ANCHR BELT EA	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1246 Home Dialysis Equipment and Supplies	
A4657	SYRINGE WITH OR WITHOUT NEEDLE EACH	Prior authorization is required for billed charges greater than $500.		
A4660	SPHYGMOMANOMETER/BP W/CUFF&STETH	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1246 Home Dialysis Equipment and Supplies	
A4663	BLOOD PRESSURE CUFF ONLY	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1246 Home Dialysis Equipment and Supplies	
A4670	AUTOMATIC BLOOD PRESSURE MONITOR	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1246 Home Dialysis Equipment and Supplies	
A4671	DISPBL CYCLR SET USED W/CYCLR DIALY	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1246 Home Dialysis Equipment and Supplies	
A4672	DRAIN EXT LINE STERILE DIALYSIS EA	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1246 Home Dialysis Equipment and Supplies	
A4673	EXT LINE W/EASY LOCK CNCTR DIALYSIS	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1246 Home Dialysis Equipment and Supplies	
A4674	CHEMS/ANTISPTC SOL CLEAN/STERL 8OZ	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1246 Home Dialysis Equipment and Supplies	
A4680	ACTIVATED CARBON FILTER HEMODIAL EA	Prior authorization is required when the billed charges are greater than $500.		
A4690	DIALYZER ALL TYPES SZS HEMODIAL EA	Prior authorization is required when the billed charges are greater than $500.		
A4706	BICARBONATE CONC SOL HEMODIAL-GAL	Prior authorization is required when the billed charges are greater than $500.		
A4707	BICARBONAT CONC PWDR HEMODIAL-PCKET	Prior authorization is required when the billed charges are greater than $500.		
A4708	ACTAT CONC SOL HEMODIAL-GALLON	Prior authorization is required when the billed charges are greater than $500.		
A4709	ACID CONC SOL HEMODIAL-GALLON	Prior authorization is required when the billed charges are greater than $500.		
A4714	TREATED H2O PERITON DIALYSIS-GALLON	Prior authorization is required when the billed charges are greater than $500.		
A4719	Y SET TUBING PERITONEAL DIALYSIS	Prior authorization is required when the billed charges are greater than $500.		
A4720	DIALYSATE FL>249<=999 CC DIALYSIS	Prior authorization is required when the billed charges are greater than $500.		
A4721	DIALYSATE FL>999<=1999CC DIALYSIS	Prior authorization is required when the billed charges are greater than $500.		
A4722	DIALYSATE FL>1999<=2999CC DIALYSIS	Prior authorization is required when the billed charges are greater than $500.		
A4723	DIALYSATE FL>2999<=3999CC DIALYSIS	Prior authorization is required when the billed charges are greater than $500.		
A4724	DIALYSATE FL>3999<=4999CC DIALYSIS	Prior authorization is required when the billed charges are greater than $500.		
A4725	DIALYSATE FL>4999<=5999CC DIALYSIS	Prior authorization is required when the billed charges are greater than $500.		
A4726	DIALYSATE DEXTROSE FL>5999 CC PD	Prior authorization is required when the billed charges are greater than $500.		
A4728	DIALYSAT SOL NO-DXTRS CNTAIN 500 ML	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1246 Home Dialysis Equipment and Supplies	
A4730	FIST CANNULAT SET HEMODIALYSIS EA	Prior authorization is required when the billed charges are greater than $500.		
A4736	TOPICAL ANESTHETIC DIALYSIS PER G	Prior authorization is required when the billed charges are greater than $500.		
A4737	INJ ANESTHETIC DIALYSIS PER 10 ML	Prior authorization is required when the billed charges are greater than $500.		
A4740	SHUNT ACCESSRY HEMODIAL ANY TYPE EA	Prior authorization is required when the billed charges are greater than $500.		
A4750	BLD TUBING ART/VENOUS HEMODIAL EA	Prior authorization is required when the billed charges are greater than $500.		
A4755	BLD TUBING ART&VENOUS HEMODIAL EA	Prior authorization is required when the billed charges are greater than $500.		
A4760	DIALYSATE SOL TST KIT PERITON EA	Prior authorization is required when the billed charges are greater than $500.		
A4765	DIALYSATE POWDER PERITON DIALYSIS	Prior authorization is required when the billed charges are greater than $500.		
A4766	DIALYSATE SOL PERITON DIALYSIS-10ML	Prior authorization is required when the billed charges are greater than $500.		
A4770	BLD COLLECTION TUBE VAC DIALYSIS-50	Prior authorization is required when the billed charges are greater than $500.		
A4771	SERUM CLOT TIME TUBE DIALYSIS-50	Prior authorization is required when the billed charges are greater than $500.		
A4772	BLD GLU TEST STRIPS DIALYSIS PER 50	Prior authorization is required when the billed charges are greater than $500.		
A4773	OCCULT BLD TEST STRIPS DIALYSIS-50	Prior authorization is required when the billed charges are greater than $500.		
A4774	AMMONIA TEST STRIPS DIALYSIS PER 50	Prior authorization is required when the billed charges are greater than $500.		
A4802	PROTAMINE SULFATE HEMODIAL-50 MG	Prior authorization is required when the billed charges are greater than $500.		
A4860	DISPBL CATH TIP PERITON DIALYSIS-10	Prior authorization is required when the billed charges are greater than $500.		
A4870	PLUMB &/ ELEC WRK HOM HEMODIAL EQP	Prior authorization is required when the billed charges are greater than $500.		
A4890	CONTRACTS REPR&MAINT HEMODIAL EQP	Prior authorization is required when the billed charges are greater than $500.		
A4911	DRAIN BAG/BOTTLE FOR DIALYSIS EACH	Prior authorization is required when the billed charges are greater than $500.		
A4913	Miscellaneous dialysis supplies, not otherwise specified	Prior authorization is required for billed charges greater than $500.		
A4918	VENOUS PRESSURE CLAMP HEMODIAL EA	Prior authorization is required when the billed charges are greater than $500.		
A4927	GLOVES NON-STERILE PER 100	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1246 Home Dialysis Equipment and Supplies	
A4928	SURGICAL MASK PER 20	Prior authorization is required when the billed charges are greater than $500.		
A4929	TOURNIQUET FOR DIALYSIS EACH	Prior authorization is required when the billed charges are greater than $500.		
A4930	GLOVES STERILE PER PAIR	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1246 Home Dialysis Equipment and Supplies	
A4931	ORL THERMOMETER REUSBL ANY TYPE EA	Prior authorization is required when the billed charges are greater than $500.		

A4932	RECTAL THERMOMETER REUSBL TYPE EA	Prior authorization is required when the billed charges are greater than $500.		
A5051	OST POUCH CLOS; W/BARRIER ATTCH EA	Prior authorization is required when the billed charges are greater than $500.		
A5052	OST POUCH CLOS; W/O BARR ATTACH EA	Prior authorization is required when the billed charges are greater than $500.		
A5053	OSTOMY POUCH CLOS; USE FACEPLATE EA	Prior authorization is required when the billed charges are greater than $500.		
A5054	OST POUCH CLOS; BARRIER W/FLNGE EA	Prior authorization is required when the billed charges are greater than $500.		
A5055	STOMA CAP	Prior authorization is required when the billed charges are greater than $500.		
A5056	OST POUCH DRAIN EXT BARRIER FLTR EA	Prior authorization is required when the billed charges are greater than $500.		
A5057	OST POUCH DRAIN BARR CONVX FLTR EA	Prior authorization is required when the billed charges are greater than $500.		
A5061	OST POUCH DRNABLE; W/BARR ATTCH EA	Prior authorization is required when the billed charges are greater than $500.		
A5062	OST POUCH DRNABL; W/O BARR ATTCH EA	Prior authorization is required when the billed charges are greater than $500.		
A5063	OST POUCH DRNABLE; BARR W/FLNGE EA	Prior authorization is required when the billed charges are greater than $500.		
A5071	OST POUCH URIN; W/BARRIER ATTCH EA	Prior authorization is required when the billed charges are greater than $500.		
A5072	OST POUCH URIN; W/O BARR ATTCH EA	Prior authorization is required when the billed charges are greater than $500.		
A5073	OST POUCH URIN; BARRIER W/FLNGE EA	Prior authorization is required when the billed charges are greater than $500.		
A5081	STOMA PLUG OR SEAL ANY TYPE	Prior authorization is required when the billed charges are greater than $500.		
A5082	CONTINENT DEVC;CATH CONTINENT STOMA	Prior authorization is required when the billed charges are greater than $500.		
A5083	CONT DEVICE STOMA ABSORPTIVE COVER	Prior authorization is required when the billed charges are greater than $500.		
A5093	OSTOMY ACCESSORY; CONVEX INSERT	Prior authorization is required when the billed charges are greater than $500.		
A5102	BEDSIDE DRN BOTTLE W/WO TUBING EA	Prior authorization is required when the billed charges are greater than $500.		
A5105	URIN SUSPENSRY LEG BAG W/WO TUBE EA	Prior authorization is required when the billed charges are greater than $500.		
A5112	URINARY DRAIN BAG LEG/ABD LATEX EA	Prior authorization is required when the billed charges are greater than $500.		
A5113	LEG STRAP; LATEX REPLCMT ONLY-SET	Prior authorization is required when the billed charges are greater than $500.		
A5114	LEG STRAP; FOAM/FABRIC REPL-SET	Prior authorization is required when the billed charges are greater than $500.		
A5120	SKIN BARRIER WIPES OR SWABS EACH	Prior authorization is required when the billed charges are greater than $500.		
A5121	SKN BARRIER; SOLID 6X6/EQUVALNT EA	Prior authorization is required when the billed charges are greater than $500.		
A5122	SKN BARRIER; SOLID 8X8/EQUVALNT EA	Prior authorization is required when the billed charges are greater than $500.		
A5126	ADHES/NON-ADHES; DISK/FOAM PAD	Prior authorization is required when the billed charges are greater than $500.		
A5131	APPLINC CLNR INCONT&OST APPLN-16 OZ	Prior authorization is required when the billed charges are greater than $500.		
A5200	PERQ CATH/TUBE ANCHR DEVC ADHES SKN	Prior authorization is required when the billed charges are greater than $500.		
A5500	DM ONLY CSTM PREP SHOE MX DNS INSRT	Prior authorization is required when the billed charges are greater than $500.		
A5501	DM ONLY CSTM PREP SHOE MOLD PTS FT	Prior authorization is required when the billed charges are greater than $500.		
A5503	DM ONLY MOD SHOE/CSTM ROLLER/ROCKER	Prior authorization is required when the billed charges are greater than $500.		
A5504	DM ONLY MOD SHOE/CSTM W/WEDGE SHOE	Prior authorization is required when the billed charges are greater than $500.		
A5505	DM ONLY MOD SHOE/CSTM W/MT BAR SHOE	Prior authorization is required when the billed charges are greater than $500.		
A5506	DM ONLY MOD SHOE/CSTM OFF SET HEEL	Prior authorization is required when the billed charges are greater than $500.		
A5507	For diabetics only, not otherwise specified modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe, per shoe	Prior authorization is required for billed charges greater than $500.		
A5508	DM ONLY DELUX FEATUR SHOE/CSTM MOLD	Prior authorization is required when the billed charges are greater than $500.		
A5510	DIAB ONLY DIR FORM COMPRS MOLD FT	Prior authorization is required when the billed charges are greater than $500.		
A5512	FOR DIAB ONLY MX DNSITY INSRT PRFAB	Prior authorization is required when the billed charges are greater than $500.		
A5513	DIA ONLY MX DN INSRT CSTM MLD P F E	Prior authorization is required when the billed charges are greater than $500.		
A5514	DIA MX DEN INS DIR CARV CSTM FAB EA	Prior authorization is required when the billed charges are greater than $500.		
A6000	NON-CNTC WND WARMING COVR W/DEVC	Prior authorization is required when the billed charges are greater than $500.		
A6010	COLLEGEN WOUND FILLR DRY FORM PER G	Prior authorization is required when the billed charges are greater than $500.		
A6011	COLLEGEN WOUND FIL GEL/PASTE PER G	Prior authorization is required when the billed charges are greater than $500.		
A6021	COLL DRESS PAD SIZE 16 SQ/LESS EA	Prior authorization is required when the billed charges are greater than $500.		
A6022	COLL DRSG STRL>16 BUT</=48 SQ IN EA	Prior authorization is required when the billed charges are greater than $500.		
A6023	COLL DRSG STERILE SZ >48 SQ IN EA	Prior authorization is required when the billed charges are greater than $500.		
A6024	COLL DRESS WND FIL STERL PER 6 IN	Prior authorization is required when the billed charges are greater than $500.		
A6025	GEL SHEET DERMAL/EPIDRMAL APPLIC EA	Prior authorization is required when the billed charges are greater than $500.		
A6154	WOUND POUCH EACH	Prior authorization is required when the billed charges are greater than $500.		
A6196	ALGINAT/OTH FIBR GELL PAD 16 SQ/<EA	Prior authorization is required when the billed charges are greater than $500.		
A6197	ALGINAT/OTH FIBR GELL >16<=48 SQEA	Prior authorization is required when the billed charges are greater than $500.		
A6198	ALGINAT/OTH FIBR GELL PAD >48 SQ EA	Prior authorization is required when the billed charges are greater than $500.		
A6199	ALGINAT/OTH FIBR GELL DRESS FIL-6IN	Prior authorization is required when the billed charges are greater than $500.		
A6203	COMPOS DRESS 16 SQ/< W/ADHES BORDR	Prior authorization is required when the billed charges are greater than $500.		
A6204	COMPOS DRESS >16 <=48 SQ W/ADHES	Prior authorization is required when the billed charges are greater than $500.		
A6205	COMPOS DRESS >48SQ W/ADHES BORDR EA	Prior authorization is required when the billed charges are greater than $500.		
A6206	CNTCT LAYR STERL 16 SQ IN/<EA DRESS	Prior authorization is required when the billed charges are greater than $500.		
A6207	CNTC LAYER > 16 SQ BUT <= 48 SQ EA	Prior authorization is required when the billed charges are greater than $500.		
A6208	CONTACT LAYER > 48 SQ EACH DRESSING	Prior authorization is required when the billed charges are greater than $500.		
A6209	FOAM DRESS STERL 16 SQ/< NO ADHES	Prior authorization is required when the billed charges are greater than $500.		
A6210	FOAM DRESS >16 <=48SQ W/O ADHES EA	Prior authorization is required when the billed charges are greater than $500.		
A6211	FOAM DRESS STERL > 48 SQ NO ADHES	Prior authorization is required when the billed charges are greater than $500.		
A6212	FOAM DRESS 16 SQ/< W/ADHES BORDR EA	Prior authorization is required when the billed charges are greater than $500.		
A6213	FOAM DRESS >16 <= 48 SQ W/ADHES EA	Prior authorization is required when the billed charges are greater than $500.		
A6214	FOAM DRESS > 48 SQ W/ADHES BORDR EA	Prior authorization is required when the billed charges are greater than $500.		
A6215	FOAM DRESSING WOUND FIL STERL PER G	Prior authorization is required when the billed charges are greater than $500.		

A6216	GAUZE NON-IMPREG NONSTERL 16 SQ/<	Prior authorization is required when the billed charges are greater than $500.		
A6217	GAUZE NON-IMPREG NONSTRL >16<=48SQ	Prior authorization is required when the billed charges are greater than $500.		
A6218	GAUZE NON-IMPREG NONSTERL > 48 SQ	Prior authorization is required when the billed charges are greater than $500.		
A6219	GAUZE NON-IMPREG STERL 16 SQ/<ADHES	Prior authorization is required when the billed charges are greater than $500.		
A6220	GAUZE NON-IMPREG >16 <=48 SQ ADHES	Prior authorization is required when the billed charges are greater than $500.		
A6221	GAUZE NON-IMPREG > 48 SQ W/ADHES	Prior authorization is required when the billed charges are greater than $500.		
A6222	GAUZ IMPREG NOT H2O/HYDRGEL 16 SQ/<	Prior authorization is required when the billed charges are greater than $500.		
A6223	GAUZ IMPREG NOT H2O/HYDRGL >16<=48	Prior authorization is required when the billed charges are greater than $500.		
A6224	GAUZ IMPREG NOT H2O/HYDROGEL >48 SQ	Prior authorization is required when the billed charges are greater than $500.		
A6228	GAUZ IMPREG WATR/NL SALINE > 16 SQ	Prior authorization is required when the billed charges are greater than $500.		
A6229	GAUZ IMPREG WATR/SALINE >16<=48 SQ	Prior authorization is required when the billed charges are greater than $500.		
A6230	GAUZ IMPREG H2O/SALINE STERL >48 SQ	Prior authorization is required when the billed charges are greater than $500.		
A6231	GAUZ IMPREG HYDRGEL DIR WND 16 SQ/<	Prior authorization is required when the billed charges are greater than $500.		
A6232	GAUZ IMPREG HYDRGEL DIR >16 <= 48	Prior authorization is required when the billed charges are greater than $500.		
A6233	GAUZ IMPREG HYDRGEL DIR WND > 48 SQ	Prior authorization is required when the billed charges are greater than $500.		
A6234	HYDRCOLLOID DRESS 16 SQ/< W/O ADHES	Prior authorization is required when the billed charges are greater than $500.		
A6235	HYDRCOLLOID DRESS >16<=48 NO ADHES	Prior authorization is required when the billed charges are greater than $500.		
A6236	HYDROCOLLOID DRESS >48 SQ W/O ADHES	Prior authorization is required when the billed charges are greater than $500.		
A6237	HYDROCOLLOID DRESS 16 SQ/< W/ADHES	Prior authorization is required when the billed charges are greater than $500.		
A6238	HYDRCOLLOID DRESS >16<= 48 W/ADHES	Prior authorization is required when the billed charges are greater than $500.		
A6239	HYDROCOLLOID DRESS > 48 SQ W/ADHES	Prior authorization is required when the billed charges are greater than $500.		
A6240	HYDROCOLLOID DRESS FIL PASTE-FL OZ	Prior authorization is required when the billed charges are greater than $500.		
A6241	HYDROCOLLOID DRESS DRY FORM PER G	Prior authorization is required when the billed charges are greater than $500.		
A6242	HYDROGEL DRESS 16 SQ/< W/O ADHES EA	Prior authorization is required when the billed charges are greater than $500.		
A6243	HYDROGEL DRESS >16 <=48SQ NO ADHES	Prior authorization is required when the billed charges are greater than $500.		
A6244	HYDROGEL DRESS > 48 SQ W/O ADHES EA	Prior authorization is required when the billed charges are greater than $500.		
A6245	HYDROGEL DRESS 16 SQ/< W/ADHES EA	Prior authorization is required when the billed charges are greater than $500.		
A6246	HYDROGEL DRESS >16 <=48 SQ W/ADHES	Prior authorization is required when the billed charges are greater than $500.		
A6247	HYDROGEL DRESS STERL >48 SQ ADHES	Prior authorization is required when the billed charges are greater than $500.		
A6248	HYDROGEL DRESS WOUND FIL GEL FL OZ	Prior authorization is required when the billed charges are greater than $500.		
A6250	SKN SEALNT PROTCT MOISTURZR OINTMNT	Prior authorization is required when the billed charges are greater than $500.		
A6251	SPCLTY ABSORB DRESS 16SQ/< NO ADHES	Prior authorization is required when the billed charges are greater than $500.		
A6252	SPCL ABSORB DRESS >16<=48 NO ADHES	Prior authorization is required when the billed charges are greater than $500.		
A6253	SPCLTY ABSORB DRESS >48 SQ NO ADHES	Prior authorization is required when the billed charges are greater than $500.		
A6254	SPCLTY ABSORB DRESS 16 SQ/< W/ADHES	Prior authorization is required when the billed charges are greater than $500.		
A6255	SPCL ABSORB DRESS >16<= 48 W/ADHES	Prior authorization is required when the billed charges are greater than $500.		
A6256	SPCLTY ABSORB DRESS > 48 SQ W/ADHES	Prior authorization is required when the billed charges are greater than $500.		
A6257	TRNSPRT FILM STERL 16 SQ/< EA DRESS	Prior authorization is required when the billed charges are greater than $500.		
A6258	TRNSPRT FILM >16 SQ BUT <=48 SQ EA	Prior authorization is required when the billed charges are greater than $500.		
A6259	TRNSPRT FILM STERL > 48 SQ EA DRESS	Prior authorization is required when the billed charges are greater than $500.		
A6260	WOUND CLEANSERS ANY TYPE ANY SIZE	Prior authorization is required when the billed charges are greater than $500.		
A6261	Wound filler, gel/paste, per fluid ounce, not otherwise specified	Prior authorization is required for billed charges greater than $500.		
A6262	Wound filler, dry form, per gram, not otherwise specified	Prior authorization is required for billed charges greater than $500.		
A6266	GAUZ IMPRG NOT H2O SAL/ZINC LINR YD	Prior authorization is required when the billed charges are greater than $500.		
A6402	GAUZ NON-IMPREG STERL 16 SQ/< NO AD	Prior authorization is required when the billed charges are greater than $500.		
A6403	GAUZ NON-IMPREG STERL >16 <= 48 SQ	Prior authorization is required when the billed charges are greater than $500.		
A6404	GAUZ NON-IMPREG STRL >48SQ NO ADHES	Prior authorization is required when the billed charges are greater than $500.		
A6407	PACK STRIPS NON-IMPREGNTD UP 2 IN	Prior authorization is required when the billed charges are greater than $500.		
A6410	EYE PAD STERILE EACH	Prior authorization is required when the billed charges are greater than $500.		
A6411	EYE PAD NON-STERILE EACH	Prior authorization is required when the billed charges are greater than $500.		
A6412	EYE PATCH OCCLUSIVE EACH	Prior authorization is required when the billed charges are greater than $500.		
A6413	ADHESIVE BANDAGE FIRST-AID TYPE EA	Prior authorization is required when the billed charges are greater than $500.		
A6441	PADD BANDGE NON-ELAST NON-WOVEN/NON	Prior authorization is required when the billed charges are greater than $500.		
A6442	CONFORMING BANDGE NON-ELAST KNITTED	Prior authorization is required when the billed charges are greater than $500.		
A6443	CONFORMING BANDGE NON-ELAST KNITTED	Prior authorization is required when the billed charges are greater than $500.		
A6444	CONFORMING BANDGE NON-ELAST KNITTED	Prior authorization is required when the billed charges are greater than $500.		
A6445	CONFORMING BANDGE NON-ELAST KNITTED	Prior authorization is required when the billed charges are greater than $500.		
A6446	CONFORMING BANDGE NON-ELAST KNITTED	Prior authorization is required when the billed charges are greater than $500.		
A6447	CONFORMING BANDGE NON-ELAST KNITTED	Prior authorization is required when the billed charges are greater than $500.		
A6448	LT COMPRS BANDGE ELAST WDTH < 3 IN	Prior authorization is required when the billed charges are greater than $500.		
A6449	LT COMPRS BANDGE WDTH >/= 3 & <5 IN	Prior authorization is required when the billed charges are greater than $500.		
A6450	LT COMPRS BANDGE WDTH >/= 5 IN	Prior authorization is required when the billed charges are greater than $500.		
A6451	MOD COMPRS BANDGE WD >/= 3 & <5 IN	Prior authorization is required when the billed charges are greater than $500.		
A6452	HI COMPRS BANDGE WD >/= 3 & <5 IN	Prior authorization is required when the billed charges are greater than $500.		
A6453	SELF-ADHERENT BANDGE WDTH </= 3 IN	Prior authorization is required when the billed charges are greater than $500.		
A6454	SLF ADHERNT BANDGE WD >/= 3 & <5 IN	Prior authorization is required when the billed charges are greater than $500.		
A6455	SELF-ADHERENT BANDGE WDTH >/= 5 IN	Prior authorization is required when the billed charges are greater than $500.		
A6456	ZINC PAST BANDGE WD >/= 3 & <5 IN	Prior authorization is required when the billed charges are greater than $500.		

A6457	TUBULR DRSG W/WO ELAST WDTH LINR YD	Prior authorization is required when the billed charges are greater than $500.		
A6460	SYN RSRB W DR STRL P 16 SI/< NO A E	Prior authorization is required when the billed charges are greater than $500.		
A6461	S RSRB ST PD SZ >16 SI </= 48 SI E	Prior authorization is required when the billed charges are greater than $500.		
A6501	COMPRS BURN GARMNT BDYSUIT CSTM FAB	Prior authorization is required when the billed charges are greater than $500.		
A6502	COMPRS BRN GARMNT CHIN STRAP CSTM	Prior authorization is required when the billed charges are greater than $500.		
A6503	COMPRS BRN GARMNT FCE HOOD CSTM FAB	Prior authorization is required when the billed charges are greater than $500.		
A6504	COMPRS BRN GARMNT GLOV WRST CSTM	Prior authorization is required when the billed charges are greater than $500.		
A6505	COMPRS BRN GARMNT GLOV ELB CSTM FAB	Prior authorization is required when the billed charges are greater than $500.		
A6506	COMPRS BURN GARMNT GLOV AX CSTM FAB	Prior authorization is required when the billed charges are greater than $500.		
A6507	COMPRS BRN GARMNT FT KNEE LEN CSTM	Prior authorization is required when the billed charges are greater than $500.		
A6508	COMPRS BRN GARMNT FT THI LEN CSTM	Prior authorization is required when the billed charges are greater than $500.		
A6509	COMPRS BRN GARMNT TRNK WAIST CSTM	Prior authorization is required when the billed charges are greater than $500.		
A6510	COMPRS BRN GARMNT TRNK ARM LEG OPN	Prior authorization is required when the billed charges are greater than $500.		
A6511	COMPRS BRN GARMNT LW TRNK LEG OPN	Prior authorization is required when the billed charges are greater than $500.		
A6512	Compression burn garment, not otherwise classified	Prior authorization is required for billed charges greater than $500.		
A6513	COMPRS BRN MASK FCE&/NCK PLSTC/EQUL	Prior authorization is required when the billed charges are greater than $500.		
A6521	Gradient compression garment, glove, padded, for nighttime use, custom, each	Prior authorization is required when the billed charges are greater than $500.		
A6522	Gradient compression garment, arm, padded, for nighttime use, each	Prior authorization is required when the billed charges are greater than $500.		
A6523	Gradient compression garment, arm, padded, for nighttime use, custom, each	Prior authorization is required when the billed charges are greater than $500.		
A6524	Gradient compression garment, lower leg and foot, padded, for nighttime use, each	Prior authorization is required when the billed charges are greater than $500.		
A6525	Gradient compression garment, lower leg and foot, padded, for nighttime use, custom, each	Prior authorization is required when the billed charges are greater than $500.		
A6526	Gradient compression garment, full leg and foot, padded, for nighttime use, each	Prior authorization is required when the billed charges are greater than $500.		
A6527	Gradient compression garment, full leg and foot, padded, for nighttime use, custom, each	Prior authorization is required when the billed charges are greater than $500.		
A6528	Gradient compression garment, bra, for nighttime use, each	Prior authorization is required when the billed charges are greater than $500.		
A6529	Gradient compression garment, bra, for nighttime use, custom, each	Prior authorization is required when the billed charges are greater than $500.		
A6530	GRADIENT COMPRS STK BK 18-30 MMHG	Prior authorization is required when the billed charges are greater than $500.		
A6531	Gradient compression stocking, below knee, 30-40 mmhg, used as a surgical dressing, each	Prior authorization is required when the billed charges are greater than $500.		
A6532	Gradient compression stocking, below knee, 40-50 mmhg, used as a surgical dressing, each	Prior authorization is required when the billed charges are greater than $500.		
A6533	GRADENT COMPRS STK THIGH 18-30 MMHG	Prior authorization is required when the billed charges are greater than $500.		
A6534	GRADENT COMPRS STK THIGH 30-40 MMHG	Prior authorization is required when the billed charges are greater than $500.		
A6535	Gradient compression stocking, thigh length, 40 mmhg or greater, each	Prior authorization is required when the billed charges are greater than $500.		
A6536	GRADENT COMPRS STK FULL 18-30 MMHG	Prior authorization is required when the billed charges are greater than $500.		
A6537	GRADENT COMPRS STK FULL 30-40 MMHG	Prior authorization is required when the billed charges are greater than $500.		
A6538	Gradient compression stocking, full length/chap style, 40 mmhg or greater, each	Prior authorization is required when the billed charges are greater than $500.		
A6539	GRADENT COMPRS STK WAIST 18-30 MMHG	Prior authorization is required when the billed charges are greater than $500.		
A6540	GRADENT COMPRS STK WAIST 30-40 MMHG	Prior authorization is required when the billed charges are greater than $500.		
A6541	Gradient compression stocking, waist length, 40 mmhg or greater, each	Prior authorization is required when the billed charges are greater than $500.		
A6544	GRADENT COMPRESSION STK GARTER BELT	Prior authorization is required when the billed charges are greater than $500.		
A6545	Gradient compression wrap, non-elastic, below knee, 30-50 mmhg, used as a surgical dressing, each	Prior authorization is required when the billed charges are greater than $500.		
A6549	Gradient compression garment, not otherwise specified	Prior authorization is required for billed charges greater than $500.		
A6550	Wound care set, for negative pressure wound therapy electrical pump, includes all supplies and accessories	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1039 Negative Pressure Wound Therapy	
A6552	Gradient compression stocking, below knee, 30-40 mmhg, each	Prior authorization is required when the billed charges are greater than $500.		
A6553	Gradient compression stocking, below knee, 30-40 mmhg, custom, each	Prior authorization is required when the billed charges are greater than $500.		
A6554	Gradient compression stocking, below knee, 40 mmhg or greater, each	Prior authorization is required when the billed charges are greater than $500.		
A6555	Gradient compression stocking, below knee, 40 mmhg or greater, custom, each	Prior authorization is required when the billed charges are greater than $500.		
A6556	Gradient compression stocking, thigh length, 18-30 mmhg, custom, each	Prior authorization is required when the billed charges are greater than $500.		
A6557	Gradient compression stocking, thigh length, 30-40 mmhg, custom, each	Prior authorization is required when the billed charges are greater than $500.		
A6558	Gradient compression stocking, thigh length, 40 mmhg or greater, custom, each	Prior authorization is required when the billed charges are greater than $500.		
A6559	Gradient compression stocking, full length/chap style, 18-30 mmhg, custom, each	Prior authorization is required when the billed charges are greater than $500.		
A6560	Gradient compression stocking, full length/chap style, 30-40 mmhg, custom, each	Prior authorization is required when the billed charges are greater than $500.		
A6561	Gradient compression stocking, full length/chap style, 40 mmhg or greater, custom, each	Prior authorization is required when the billed charges are greater than $500.		
A6562	Gradient compression stocking, waist length, 18-30 mmhg, custom, each	Prior authorization is required when the billed charges are greater than $500.		
A6563	Gradient compression stocking, waist length, 30-40 mmhg, custom, each	Prior authorization is required when the billed charges are greater than $500.		
A6564	Gradient compression stocking, waist length, 40 mmhg or greater, custom, each	Prior authorization is required when the billed charges are greater than $500.		
A6565	Gradient compression gauntlet, custom, each	Prior authorization is required when the billed charges are greater than $500.		
A6566	Gradient compression garment, neck/head, each	Prior authorization is required when the billed charges are greater than $500.		
A6567	Gradient compression garment, neck/head, custom, each	Prior authorization is required when the billed charges are greater than $500.		
A6568	Gradient compression garment, torso and shoulder, each	Prior authorization is required when the billed charges are greater than $500.		
A6569	Gradient compression garment, torso/shoulder, custom, each	Prior authorization is required when the billed charges are greater than $500.		
A6570	Gradient compression garment, genital region, each	Prior authorization is required when the billed charges are greater than $500.		
A6571	Gradient compression garment, genital region, custom, each	Prior authorization is required when the billed charges are greater than $500.		
A6572	Gradient compression garment, toe caps, each	Prior authorization is required when the billed charges are greater than $500.		

A6573	Gradient compression garment, toe caps, custom, each	Prior authorization is required when the billed charges are greater than $500.		
A6574	Gradient compression arm sleeve and glove combination, custom, each	Prior authorization is required when the billed charges are greater than $500.		
A6575	Gradient compression arm sleeve and glove combination, each	Prior authorization is required when the billed charges are greater than $500.		
A6576	Gradient compression arm sleeve, custom, medium weight, each	Prior authorization is required when the billed charges are greater than $500.		
A6577	Gradient compression arm sleeve, custom, heavy weight, each	Prior authorization is required when the billed charges are greater than $500.		
A6578	Gradient compression arm sleeve, each	Prior authorization is required when the billed charges are greater than $500.		
A6579	Gradient compression glove, custom, medium weight, each	Prior authorization is required when the billed charges are greater than $500.		
A6580	Gradient compression glove, custom, heavy weight, each	Prior authorization is required when the billed charges are greater than $500.		
A6581	Gradient compression glove, each	Prior authorization is required when the billed charges are greater than $500.		
A6582	Gradient compression gauntlet, each	Prior authorization is required when the billed charges are greater than $500.		
A6583	Gradient compression wrap with adjustable straps, below knee, 30-50 mmhg, each	Prior authorization is required when the billed charges are greater than $500.		
A6584	Gradient compression wrap with adjustable straps, not otherwise specified	Prior authorization is required when the billed charges are greater than $500.		
A6585	Gradient pressure wrap with adjustable straps, above knee, each	Prior authorization is required when the billed charges are greater than $500.		
A6586	Gradient pressure wrap with adjustable straps, full leg, each	Prior authorization is required when the billed charges are greater than $500.		
A6587	Gradient pressure wrap with adjustable straps, foot, each	Prior authorization is required when the billed charges are greater than $500.		
A6588	Gradient pressure wrap with adjustable straps, arm, each	Prior authorization is required when the billed charges are greater than $500.		
A6589	Gradient pressure wrap with adjustable straps, bra, each	Prior authorization is required when the billed charges are greater than $500.		
A6593	Accessory for gradient compression garment or wrap with adjustable straps, non-otherwise specified	Prior authorization is required when the billed charges are greater than $500.		
A6594	Gradient compression bandaging supply, bandage liner, lower extremity, any size or length, each	Prior authorization is required when the billed charges are greater than $500.		
A6595	Gradient compression bandaging supply, bandage liner, upper extremity, any size or length, each	Prior authorization is required when the billed charges are greater than $500.		
A6596	Gradient compression bandaging supply, conforming gauze, per linear yard, any width, each	Prior authorization is required when the billed charges are greater than $500.		
A6597	Gradient compression bandage roll, elastic long stretch, linear yard, any width, each	Prior authorization is required when the billed charges are greater than $500.		
A6598	Gradient compression bandage roll, elastic medium stretch, per linear yard, any width, each	Prior authorization is required when the billed charges are greater than $500.		
A6599	Gradient compression bandage roll, inelastic short stretch, per linear yard, any width, each	Prior authorization is required when the billed charges are greater than $500.		
A6600	Gradient compression bandaging supply, high density foam sheet, per 250 square centimeters, each	Prior authorization is required when the billed charges are greater than $500.		
A6601	Gradient compression bandaging supply, high density foam pad, any size or shape, each	Prior authorization is required when the billed charges are greater than $500.		
A6602	Gradient compression bandaging supply, high density foam roll for bandage, per linear yard, any width, each	Prior authorization is required when the billed charges are greater than $500.		
A6603	Gradient compression bandaging supply, low density channel foam sheet, per 250 square centimeters, each	Prior authorization is required when the billed charges are greater than $500.		
A6604	Gradient compression bandaging supply, low density flat foam sheet, per 250 square centimeters, each	Prior authorization is required when the billed charges are greater than $500.		
A6605	Gradient compression bandaging supply, padded foam, per linear yard, any width, each	Prior authorization is required when the billed charges are greater than $500.		
A6606	Gradient compression bandaging supply, padded textile, per linear yard, any width, each	Prior authorization is required when the billed charges are greater than $500.		
A6607	Gradient compression bandaging supply, tubular protective absorption layer, per linear yard, any width, each	Prior authorization is required when the billed charges are greater than $500.		
A6608	Gradient compression bandaging supply, tubular protective absorption padded layer, per linear yard, any width, each	Prior authorization is required when the billed charges are greater than $500.		
A6609	Gradient compression bandaging supply, not otherwise specified	Prior authorization is required when the billed charges are greater than $500.		
A6610	Gradient compression stocking, below knee, 18-30 mmhg, custom, each	Prior authorization is required when the billed charges are greater than $500.		
A7000	Canister, disposable, used with suction pump, each	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1039 Negative Pressure Wound Therapy	
A7001	Canister, nondisposable, used with suction pump, each	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1039 Negative Pressure Wound Therapy	
A7002	Tubing, used with suction pump, each	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1063 Devices Used for the Treatment of Obstructive Sleep Apnea in Adults	
A7003	ADMN SET SM VOL NONFILTR NEB DISPBL	Prior authorization is required when the billed charges are greater than $500.		
A7004	SM VOL NONFILTR PNEUMAT NEB DISPBL	Prior authorization is required when the billed charges are greater than $500.		
A7005	ADMN SET SM VOL NONFLTR NEB NONDISP	Prior authorization is required when the billed charges are greater than $500.		
A7006	ADMN SET W/SM VOL FILTR NEBULIZR	Prior authorization is required when the billed charges are greater than $500.		
A7007	LG VOL NEBULIZR DISPBL UNFIL COMPRS	Prior authorization is required when the billed charges are greater than $500.		
A7008	LG VOL NEBULIZR DISPBL PRFIL COMPRS	Prior authorization is required when the billed charges are greater than $500.		
A7009	RESRVOR BOTTLE LG VOL US NEBULIZR	Prior authorization is required when the billed charges are greater than $500.		
A7010	CORUG TUBE DISPBL LG VOL NEB 100 FT	Prior authorization is required when the billed charges are greater than $500.		
A7012	WATER COLLEC DEV USE W/LG VOL NEB	Prior authorization is required when the billed charges are greater than $500.		
A7013	FILTER DISP W/AREO COMPRESS/US GEN	Prior authorization is required when the billed charges are greater than $500.		
A7014	FLTR NON-DISPBL AROSL COMPRS/US GEN	Prior authorization is required when the billed charges are greater than $500.		
A7015	AREO MASK USED W/ DME NEB	Prior authorization is required when the billed charges are greater than $500.		
A7016	DOME&MOUTHPECE W/SM VOL US NEBULIZR	Prior authorization is required when the billed charges are greater than $500.		
A7017	NEB GLASS/AUTOCLAV NOT USE W/O2	Prior authorization is required when the billed charges are greater than $500.		
A7018	H2O DIST USE W/LG VOL NEB 1000 ML	Prior authorization is required when the billed charges are greater than $500.		
A7020	INTERFACE COUGH STIM DEVC REPL ONLY	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1141 High Frequency Chest Wall Oscillation Devices	

A7025	HI FREQ CHST WALL OSCILAT VEST REPL	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1141 High Frequency Chest Wall Oscillation Devices	
A7026	HI FREQ CHST WALL OSCILAT HOSE REPL	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1141 High Frequency Chest Wall Oscillation Devices	
A7027	Combination oral/nasal mask, used with continuous positive airway pressure device, each	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1063 Devices Used for the Treatment of Obstructive Sleep Apnea in Adults and HHO-DE-MP-1076 Respiratory Assist Devices	
A7028	Oral cushion for combination oral/nasal mask, replacement only, each	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1063 Devices Used for the Treatment of Obstructive Sleep Apnea in Adults and HHO-DE-MP-1076 Respiratory Assist Devices	
A7029	Nasal pillows for combination oral/nasal mask, replacement only, pair	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1063 Devices Used for the Treatment of Obstructive Sleep Apnea in Adults and HHO-DE-MP-1076 Respiratory Assist Devices	
A7030	Full face mask used with positive airway pressure device, each	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1063 Devices Used for the Treatment of Obstructive Sleep Apnea in Adults and HHO-DE-MP-1076 Respiratory Assist Devices	
A7031	Face mask interface, replacement for full face mask, each	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1076 Respiratory Assist Devices	
A7032	Cushion for use on nasal mask interface, replacement only, each	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1076 Respiratory Assist Devices	
A7033	Pillow for use on nasal cannula type interface, replacement only, pair	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1063 Devices Used for the Treatment of Obstructive Sleep Apnea in Adults and HHO-DE-MP-1076 Respiratory Assist Devices	
A7034	Nasal interface (mask or cannula type) used with positive airway pressure device, with or without head strap	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1063 Devices Used for the Treatment of Obstructive Sleep Apnea in Adults and HHO-DE-MP-1076 Respiratory Assist Devices	
A7035	Headgear used with positive airway pressure device	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1063 Devices Used for the Treatment of Obstructive Sleep Apnea in Adults and HHO-DE-MP-1076 Respiratory Assist Devices	
A7036	Chinstrap used with positive airway pressure device	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1063 Devices Used for the Treatment of Obstructive Sleep Apnea in Adults and HHO-DE-MP-1076 Respiratory Assist Devices	
A7037	Tubing used with positive airway pressure device	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1063 Devices Used for the Treatment of Obstructive Sleep Apnea in Adults and HHO-DE-MP-1076 Respiratory Assist Devices	
A7038	Filter, disposable, used with positive airway pressure device	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1063 Devices Used for the Treatment of Obstructive Sleep Apnea in Adults and HHO-DE-MP-1076 Respiratory Assist Devices	
A7039	Filter, nondisposable, used with positive airway pressure device	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1063 Devices Used for the Treatment of Obstructive Sleep Apnea in Adults and HHO-DE-MP-1076 Respiratory Assist Devices	
A7040	ONE WAY CHEST DRAIN VALVE	Prior authorization is required when the billed charges are greater than $500.		
A7041	WATER SEAL DRNAGE CONTAINER&TUBING	Prior authorization is required when the billed charges are greater than $500.		
A7044	Oral interface used with positive airway pressure device, each	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1063 Devices Used for the Treatment of Obstructive Sleep Apnea in Adults and HHO-DE-MP-1076 Respiratory Assist Devices	
A7045	Exhalation port with or without swivel used with accessories for positive airway devices, replacement only	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1063 Devices Used for the Treatment of Obstructive Sleep Apnea in Adults and HHO-DE-MP-1076 Respiratory Assist Devices	
A7046	Water chamber for humidifier, used with positive airway pressure device, replacement, each	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1063 Devices Used for the Treatment of Obstructive Sleep Apnea in Adults and HHO-DE-MP-1076 Respiratory Assist Devices	
A7047	Oral interface used with respiratory suction pump, each	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1063 Devices Used for the Treatment of Obstructive Sleep Apnea in Adults	
A7048	VACUUM DRN CLCT U & TUBING KIT EA	Prior authorization is required when the billed charges are greater than $500.		
A7501	TRACHEOSTOMA VALV INCL DIAPHRAGM EA	Prior authorization is required when the billed charges are greater than $500.		
A7502	REPL DIAPH/FCEPLAT TRACHESTOMA VALV	Prior authorization is required when the billed charges are greater than $500.		
A7503	FLTR HOLDER/CAP REUSBL TRACHEOSTOMA	Prior authorization is required when the billed charges are greater than $500.		
A7504	FLTR USE TRACHEOSTOMA EXCHG SYS EA	Prior authorization is required when the billed charges are greater than $500.		
A7505	HOUS REUSABL W/O ADHES EXCHG SYS	Prior authorization is required when the billed charges are greater than $500.		
A7506	ADHES DISC EXCHG SYS&/ W/TRACH VALV	Prior authorization is required when the billed charges are greater than $500.		
A7507	FLTR HLDR&INTGR FLTR TRACHEOSTOMA	Prior authorization is required when the billed charges are greater than $500.		
A7508	HOUS&INTGR ADHES EXCHG SYS &/ VALV	Prior authorization is required when the billed charges are greater than $500.		
A7509	FLTR HLDR&INTGR FLTR HOUS&ADHES	Prior authorization is required when the billed charges are greater than $500.		
A7520	TRACHEOST/LARYNGECT TUBE NON-CUFFED	Prior authorization is required when the billed charges are greater than $500.		
A7521	TRACHEOST/LARYNGECT TUBE CUFF PVC	Prior authorization is required when the billed charges are greater than $500.		
A7522	TRACHEOST/LARYNGECT TUBE STNLESS ST	Prior authorization is required when the billed charges are greater than $500.		
A7523	TRACHEOSTOMY SHOWER PROTECTOR EACH	Prior authorization is required when the billed charges are greater than $500.		
A7524	TRACHEOSTOMA STENT/STUD/BUTTON EACH	Prior authorization is required when the billed charges are greater than $500.		

A7525	TRACHEOSTOMY MASK EACH	Prior authorization is required when the billed charges are greater than $500.		
A7526	TRACHEOSTOMY TUBE COLLAR/HOLDER EA	Prior authorization is required when the billed charges are greater than $500.		
A7527	TRACHEOST/LRYNGCT TUBE PLUG/STOP EA	Prior authorization is required when the billed charges are greater than $500.		
A8000	HELMET PROTECTIVE SOFT PREFAB	Prior authorization is required when the billed charges are greater than $500.		
A8001	HELMET PROTECTIVE HARD PREFAB	Prior authorization is required when the billed charges are greater than $500.		
A8002	HELMET PROTECTIVE SOFT CUSTOM FAB	Prior authorization is required when the billed charges are greater than $500.		
A8003	HELMET PROTECTIVE HARD CUSTOM FAB	Prior authorization is required when the billed charges are greater than $500.		
A8004	SOFT INTERFACE FOR HELMET REPL ONLY	Prior authorization is required when the billed charges are greater than $500.		
A9150	NONPRESCRIPTION DRUG	Prior authorization is required when the billed charges are greater than $500.		
A9152	Single vitamin/mineral/trace element, oral, per dose, not otherwise specified	Prior authorization is required for billed charges greater than $500.		
A9153	Multiple vitamins, with or without minerals and trace elements, oral, per dose, not otherwise specified	Prior authorization is required for billed charges greater than $500.		
A9155	ARTFICIAL SALIVA 30 ML	Prior authorization is required when the billed charges are greater than $500.		
A9270	NONCOVERED ITEM OR SERVICE	Prior authorization is required when the billed charges are greater than $500.		
A9272	WND SCTN DISPBL DRSG ACC ANY TYP EA	Prior authorization is required when the billed charges are greater than $500.		
A9273	COLD/HOT FL BTL IC/C HT&/CLD W ANY	Prior authorization is required when the billed charges are greater than $500.		
A9274	EXT AMB INSULIN DEL SYS DISPOSBL EA	Prior authorization is required when the billed charges are greater than $500.		
A9275	HOME GLU DISPBL MON W/TEST STRIPS	Prior authorization is required when the billed charges are greater than $500.		
A9276	SENSOR; INVSV INTRSTL GLU MON SYS	Prior authorization is required when the billed charges are greater than $500.		
A9277	TRANSMTR; EXT INTRSTL CONT GLU MON	Prior authorization is required when the billed charges are greater than $500.		
A9278	RECEIVER MON; EXT INTRSTL GLU MON	Prior authorization is required when the billed charges are greater than $500.		
A9279	Monitoring feature/device, stand-alone or integrated, any type, includes all accessories, components and electronics, not otherwise classified	Prior authorization is required for billed charges greater than $500.		
A9280	Alert or alarm device, not otherwise classified	Prior authorization is required for billed charges greater than $500.		
A9281	REACH/GRABBING DEVC ANY TYPE/LEN EA	Prior authorization is required when the billed charges are greater than $500.		
A9282	WIG ANY TYPE EACH	Prior authorization is required when the billed charges are greater than $500.		
A9283	FOOT PRESSURE OFF LOAD/SUPP DEV EA	Prior authorization is required when the billed charges are greater than $500.		
A9284	SPIROMETER NONELECTRONC INCL ACCESS	Prior authorization is required when the billed charges are greater than $500.		
A9285	INVERSION/EVERSION CORRECTION DEVC	Prior authorization is required when the billed charges are greater than $500.		
A9286	HYG I/DVC DISPBL/NON-DISPBL ANY T E	Prior authorization is required when the billed charges are greater than $500.		
A9900	Miscellaneous dme supply, accessory and/or service component of another hcpcs code	Prior authorization is required for billed charges greater than $500.		
A9901	DME DEL SET&/DSPNS SRVC ANOTH HCPCS	Prior authorization is required when the billed charges are greater than $500.		
A9999	Miscellaneous dme supply or accessory, not otherwise specified	Prior authorization is required for billed charges greater than $500.		
B4034	ENTERAL FEED SPL KIT; SYRINGE DAY	Prior authorization is required when the billed charges are greater than $500.		
B4035	ENTERAL FEED SPL KIT; PUMP FED-DAY	Prior authorization is required when the billed charges are greater than $500.		
B4036	ENTERAL FD SPL KIT; GRAVITY FED-DAY	Prior authorization is required when the billed charges are greater than $500.		
B4081	NASOGASTRIC TUBING WITH STYLET	Prior authorization is required when the billed charges are greater than $500.		
B4082	NASOGASTRIC TUBING WITHOUT STYLET	Prior authorization is required when the billed charges are greater than $500.		
B4083	STOMACH TUBE - LEVINE TYPE	Prior authorization is required when the billed charges are greater than $500.		
B4087	GASTROSTOMY/J-TUBE STANDARD EACH	Prior authorization is required when the billed charges are greater than $500.		
B4088	GASTROSTOMY/J-TUBE LOW-PROFILE EA	Prior authorization is required when the billed charges are greater than $500.		
B4100	FOOD THICKENER ADMINED ORALLY-OUNCE	Prior authorization is required when the billed charges are greater than $500.		
B4102	ENTRAL F ADLT REPL FL&LYTES 500 ML	Prior authorization is required when the billed charges are greater than $500.		
B4103	ENTRAL F PED REPL FL&LYTES 500 ML	Prior authorization is required when the billed charges are greater than $500.		
B4104	ADDITIVE FOR ENTERAL FORMULA	Prior authorization is required when the billed charges are greater than $500.		
B4105	In-line cartridge containing digestive enzyme(s) for enteral feeding, each	Not covered for member ages 5 and under. Prior authorization is required when the billed charges are greater than $500. Reference policies for additional information.	HHO-DE-MP-1010 Enteral Feeding In-Line Cartridge	
B4149	ENTRAL F MANF BLNDRIZD NAT FOODS	Prior authorization is required when the billed charges are greater than $500. Reference policies for additional information.	HHO-DE-MP-1010 Enteral Feeding In-Line Cartridge	
B4150	ENTRAL F NUTRITIONALLY COMPLETE	Prior authorization is required when the billed charges are greater than $500. Reference policies for additional information.	HHO-DE-MP-1010 Enteral Feeding In-Line Cartridge	
B4152	ENTRAL F NUTRITION CMPL CAL DENSE	Prior authorization is required when the billed charges are greater than $500. Reference policies for additional information.	HHO-DE-MP-1010 Enteral Feeding In-Line Cartridge	
B4153	ENTRL F NUTRTN CMPL HYDROLYZD PROTS	Prior authorization is required when the billed charges are greater than $500.		
B4154	ENTRAL F CMPL NO INHERITED DZ METAB	Prior authorization is required when the billed charges are greater than $500.		
B4155	ENTRAL F NUTRITN INCMPL/MOD NUTRNTS	Prior authorization is required when the billed charges are greater than $500.		
B4157	ENTRAL F CMPL INHERITED DZ METAB	Prior authorization is required when the billed charges are greater than $500. Reference policies for additional information.	HHO-DE-MP-1010 Enteral Feeding In-Line Cartridge	
B4158	ENTRAL F PED NUTRITION COMPLETE	Prior authorization is required when the billed charges are greater than $500.		
B4159	ENTRAL F PED NUTRITN CMPL SOY BASD	Prior authorization is required when the billed charges are greater than $500.		
B4160	ENTRAL F PED NUTRITN CMPL CAL DENSE	Prior authorization is required when the billed charges are greater than $500.		
B4161	ENTRAL F PED HYDROLYZED/AA PROTEINS	Prior authorization is required when the billed charges are greater than $500.		
B4162	ENTRAL F PED INHERITED DZ METAB	Prior authorization is required when the billed charges are greater than $500. Reference policies for additional information.	HHO-DE-MP-1010 Enteral Feeding In-Line Cartridge	

B4164	PARNTRAL NUT SOL; CARBS 50%/< HOM	Prior authorization is required when the billed charges are greater than $500.		
B4168	PARNTRAL NUT SOL; AMINO ACID 3.5%	Prior authorization is required when the billed charges are greater than $500.		
B4172	PARNTRAL NUT SOL; AMINO ACID 5.5-7%	Prior authorization is required when the billed charges are greater than $500.		
B4176	PARNTRAL NUT SOL; AMINO ACID 7-8.5%	Prior authorization is required when the billed charges are greater than $500.		
B4178	PARNTRAL NUT SOL; AMINO ACID > 8.5%	Prior authorization is required when the billed charges are greater than $500.		
B4180	PARNTRAL NUT SOL; CARBS > 50% HOM	Prior authorization is required when the billed charges are greater than $500.		
B4185	Parenteral nutrition solution, not otherwise specified, 10 grams lipids	Prior authorization is required for billed charges greater than $500.		
B4187	OMEGAVEN 10 G LIPIDS	Prior authorization is required when the billed charges are greater than $500.		
B4189	PARNTRAL NUT;AMINOACID&CARB 10-51GM	Prior authorization is required when the billed charges are greater than $500.		
B4193	PARNTRAL NUT;AMINOACID&CARB 52-73GM	Prior authorization is required when the billed charges are greater than $500.		
B4197	PARNTRL NUT;AMINOACID&CARB 74-100GM	Prior authorization is required when the billed charges are greater than $500.		
B4199	PARNTRAL NUT;AMINO ACID&CARB >100GM	Prior authorization is required when the billed charges are greater than $500.		
B4216	PARNTRAL NUT; ADDITIVES-HOM MIX-DAY	Prior authorization is required when the billed charges are greater than $500.		
B4220	PARNTRAL NUTRIT SPL KIT; PREMIX-DAY	Prior authorization is required when the billed charges are greater than $500.		
B4222	PARNTRAL NUT SPL KIT; HOM MIX-DAY	Prior authorization is required when the billed charges are greater than $500.		
B4224	PARNTRAL NUTRITION ADMIN KIT-DAY	Prior authorization is required when the billed charges are greater than $500.		
B5000	PARNTRAL NUT; AMINO ACID&CARBS RENL	Prior authorization is required when the billed charges are greater than $500.		
B5100	PARENTERL NUT SOL AMINO ACID & CARB	Prior authorization is required when the billed charges are greater than $500.		
B5200	PARNTRL NUT AMINO ACID & CARS STRSS	Prior authorization is required when the billed charges are greater than $500.		
B9002	ENTERAL NUTR INFUSION PUMP ANY TYPE	Prior authorization is required when the billed charges are greater than $500.		
B9004	PARNTRAL NUTRIT INFUS PUMP PRTBLE	Prior authorization is required when the billed charges are greater than $500.		
B9006	PARNTRAL NUTRIT INFUS PUMP STATION	Prior authorization is required when the billed charges are greater than $500.		
B9998	NOC FOR ENTERAL SUPPLIES	Prior authorization is required when the billed charges are greater than $500.		
B9999	NOC FOR PARENTERAL SUPPLIES	Prior authorization is required when the billed charges are greater than $500.		
C1725	Catheter, transluminal angioplasty, nonlaser (may include guidance, infusion/perfusion capability)	Prior authorization is required.		
C1789	Prosthesis, breast (implantable)	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service.		
C1874	Stent, coated/covered, with delivery system	Prior authorization is required.		
C1876	Stent, noncoated/noncovered, with delivery system	Prior authorization is required.		
C1885	Catheter, transluminal angioplasty, laser	Prior authorization is required.		
C1889	Implantable/insertable device, not otherwise classified	Prior authorization is required for billed charges greater than $500.		
C2625	Stent, noncoronary, temporary, with delivery system	Prior authorization is required.		
C7903	Group psychotherapy service for diagnosis, evaluation, or treatment of a mental health or substance use disorder provided remotely by hospital staff who are licensed to provide mental health services under applicable state law(s), when the patient is in…			
C8900	MRA Abdomen with contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
C8901	MRA Abdomen without contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
C8902	MRA Abdomen with and w/o contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
C8903	MRI Breast w/ contrast, unilateral	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
C8904	MRI Breast w/o contrast, unilateral	Prior authorization is required.		
C8905	MRI Breast w. and w/o contrast, unilateral	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
C8906	MRI Breast Bilateral W/ Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
C8907	MRI Breast Bilateral W/O Contrast	Prior authorization is required.		
C8908	MRI Breast Bilateral W/ And W/O Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
C8909	MRA chest w/contrast (excluding myocardium)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
C8910	MRA chest w/o contrast (excluding myocardium)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
C8911	MRA chest w/ and w/o contrast (excluding myocardium)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
C8912	MRA lower extremity w/ contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
C8913	MRA lower extremity w/o contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
C8914	MRA lower extremity w/ and w/o contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
C8918	MRA pelvis w/ contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
C8919	MRA pelvis w/o contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
C8920	MRA pelvis w/ and w/o contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.

C8921	Transthoracic echocardiography w/contrast for congenital cardiac anomalies; complete	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
C8922	Transthoracic echocardiography w/contrast for congenital cardiac anomalies; f/u or limited study	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
C8923	Transthoracic echocardiography w/contrast, real-time w/image documentation (2d), w/wo m-mode recording; complete	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
C8924	Transthoracic echocardiography w/contrast, real-time w/image documentation (2d), w/wo m-mode recording; f/u or limited study	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
C8925	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	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
C8926	Transesophageal echocardiography (TEE) with contrast, or without contrast followed by with contrast, for congenital cardiac anomalies; including probe placement, image acquisition, interpretation and report	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
C8928	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	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
C8929	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	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
C8930	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	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
C8931	MRA, W/ Dye, Spinal Canal	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
C8932	MRA, W/O Dye, Spinal Canal	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
C8933	MRA, W/O & W/ Dye, Spinal Canal	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
C8934	MRA, W/ Dye, Upper Extremity	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
C8935	MRA, W/O Dye, Upper Extr	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
C8936	MRA, W/O & W/ Dye, Upper Extr	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
C9727	Insertion of implants into the soft palate; minimum of three implants	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1064 Diagnosis and Treatment of Obstructive Sleep Apnea in Adults	
C9757	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and excision of herniated intervertebral disc and repair of annular defect with implantation of bone anchored annular closure device, including annular defect measurement, alignment and sizing assessment and image guidance; 1 interspace, lumbar	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
C9762 *	Cardiac magnetic resonance imaging for morphology and function, quantification of segmental dysfunction; with strain imaging	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
C9763 *	Cardiac magnetic resonance imaging for morphology and function, quantification of segmental dysfunction; with stress imaging	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
C9791	Magnetic resonance imaging with inhaled hyperpolarized xenon-129 contrast agent, chest, including preparation and administration of agent	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
C9793	3d predictive model generation for pre-planning of a cardiac procedure, using data from cardiac computed tomographic angiography with report			
C9795	Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance and real-time positron emissions-based delivery adjustments to 1 or more lesions, entire course not to exceed 5 fractions			
D0120	PERIODIC ORAL EVALUATION	Coverage is managed by United Concordia Dental		
D0140	LIMIT ORAL EVAL PROBLM FOCUS	Coverage is managed by United Concordia Dental		
D0150	COMPREHENSVE ORAL EVALUATION	Coverage is managed by United Concordia Dental		
D0160	EXTENSV ORAL EVAL PROB FOCUS	Coverage is managed by United Concordia Dental		
D0170	RE-EVAL,EST PT,PROBLEM FOCUS	Coverage is managed by United Concordia Dental		
D0180	COMP PERIODONTAL EVALUATION	Coverage is managed by United Concordia Dental		
D0210	INTRAOR COMPLETE FILM SERIES	Coverage is managed by United Concordia Dental		
D0220	INTRAORAL PERIAPICAL FIRST	Coverage is managed by United Concordia Dental		
D0230	INTRAORAL PERIAPICAL EA ADD	Coverage is managed by United Concordia Dental		
D0272	DENTAL BITEWINGS TWO IMAGES	Coverage is managed by United Concordia Dental		
D0274	BITEWINGS FOUR IMAGES	Coverage is managed by United Concordia Dental		
D0330	PANORAMIC IMAGE	Coverage is managed by United Concordia Dental		
D1110	DENTAL PROPHYLAXIS ADULT	Coverage is managed by United Concordia Dental		
D1206	TOPICAL FLUORIDE VARNISH	Coverage is managed by United Concordia Dental		

D1208	TOPICAL APP FLUORID EX VRNSH	Coverage is managed by United Concordia Dental		
D1354	INT CARIES MED APP PER TOOTH	Coverage is managed by United Concordia Dental		
D2140	AMALGAM ONE SURFACE PERMANEN	Coverage is managed by United Concordia Dental		
D2150	AMALGAM TWO SURFACES PERMANE	Coverage is managed by United Concordia Dental		
D2160	AMALGAM THREE SURFACES PERMA	Coverage is managed by United Concordia Dental		
D2161	AMALGAM 4 OR > SURFACES PERM	Coverage is managed by United Concordia Dental		
D2330	RESIN ONE SURFACE-ANTERIOR	Coverage is managed by United Concordia Dental		
D2331	RESIN TWO SURFACES-ANTERIOR	Coverage is managed by United Concordia Dental		
D2332	RESIN THREE SURFACES-ANTERIO	Coverage is managed by United Concordia Dental		
D2335	RESIN 4/> SURF OR W INCIS AN	Coverage is managed by United Concordia Dental		
D2390	ANT RESIN-BASED CMPST CROWN	Coverage is managed by United Concordia Dental		
D2391	POST 1 SRFC RESINBASED CMPST	Coverage is managed by United Concordia Dental		
D2392	POST 2 SRFC RESINBASED CMPST	Coverage is managed by United Concordia Dental		
D2393	POST 3 SRFC RESINBASED CMPST	Coverage is managed by United Concordia Dental		
D2394	POST >=4SRFC RESINBASE CMPST	Coverage is managed by United Concordia Dental		
D2920	RE-CEMENT OR RE-BOND CROWN	Coverage is managed by United Concordia Dental		
D4341	PERIODONTAL SCALING AND ROOT PLANING - FOUR OR MORE TEETH PER QUADRANT	Coverage is managed by United Concordia Dental		
D4342	periodontal scaling and root planing - one to three teeth per quadrant	Coverage is managed by United Concordia Dental		
D4355	FULL MOUTH DEBRIDEMENT	Coverage is managed by United Concordia Dental		
D4910	PERIODONTAL MAINT PROCEDURES	Coverage is managed by United Concordia Dental		
D5511	REP BROKE COMP DENT BASE MAN	Coverage is managed by United Concordia Dental		
D5512	REP BROKE COMP DENT BASE MAX	Coverage is managed by United Concordia Dental		
D5520	REPLACE DENTURE TEETH COMPLT	Coverage is managed by United Concordia Dental		
D5630	REP PARTIAL DENTURE CLASP	Coverage is managed by United Concordia Dental		
D5640	REPLACE PART DENTURE TEETH	Coverage is managed by United Concordia Dental		
D5650	ADD TOOTH TO PARTIAL DENTURE	Coverage is managed by United Concordia Dental		
D5660	ADD CLASP TO PARTIAL DENTURE	Coverage is managed by United Concordia Dental		
D5750	DENTURE RELN CMPLT MAX INDIR	Coverage is managed by United Concordia Dental		
D5751	DENTURE RELN CMPLT MAND IND	Coverage is managed by United Concordia Dental		
D6930	RECEMENT/BOND PART DENTURE	Coverage is managed by United Concordia Dental		
D7140	EXTRACTION ERUPTED TOOTH/EXR	Coverage is managed by United Concordia Dental		
D7210	REM IMP TOOTH W MUCOPER FLP	Coverage is managed by United Concordia Dental		
D7220	IMPACT TOOTH REMOV SOFT TISS	Coverage is managed by United Concordia Dental		
D7250	TOOTH ROOT REMOVAL	Coverage is managed by United Concordia Dental		
D7510	I&D ABSC INTRAORAL SOFT TISS	Coverage is managed by United Concordia Dental		
D7520	I&D ABSCESS EXTRAORAL	Coverage is managed by United Concordia Dental		
D7521	INCISION/DRAIN ABSCESS EXTRA	Coverage is managed by United Concordia Dental		
D9110	TX DENTAL PAIN MINOR PROC	Coverage is managed by United Concordia Dental		
D9222	DEEP ANEST, 1ST 15 MIN	Coverage is managed by United Concordia Dental		
D9223	GENERAL ANESTH EA ADDL 15 MI	Coverage is managed by United Concordia Dental		
D9230	ANALGESIA	Coverage is managed by United Concordia Dental		
D9239	IV MOD SEDATION, 1ST 15 MIN	Coverage is managed by United Concordia Dental		
D9243	IV SEDATION EA ADDL 15M	Coverage is managed by United Concordia Dental		
D9248	SEDATION (NON-IV)	Coverage is managed by United Concordia Dental		
D9995	TELEDENTISTRY REAL-TIME	Coverage is managed by United Concordia Dental		
D9996	TELEDENTISTRY DENT REVIEW	Coverage is managed by United Concordia Dental		
E0100	CANE ALL MATL ADJUSTBLE/FIXED W/TIP	Prior authorization is required when the billed charges are greater than $500.		
E0105	CANE QUAD/3-PRONG ALL MATL W/TIPS	Prior authorization is required when the billed charges are greater than $500.		
E0110	CRTCHES FORARM VARIOUS MATL PAIR	Prior authorization is required when the billed charges are greater than $500.		
E0111	CRTCH FORARM VARIOUS MATL EA	Prior authorization is required when the billed charges are greater than $500.		
E0112	CRTCHS UNDARM WOOD PAIR ADJSTBL/FIX	Prior authorization is required when the billed charges are greater than $500.		
E0113	CRTCH UNDARM WOOD EA ADJUSTBL/FIX	Prior authorization is required when the billed charges are greater than $500.		
E0114	CRTCHES UNDARM OTH THAN WOOD PAIR	Prior authorization is required when the billed charges are greater than $500.		
E0116	CRTCH UNDARM OTH THAN WOOD ADJ/FIX	Prior authorization is required when the billed charges are greater than $500.		
E0117	CRTCH UNDERARM ARTIC SPRNG ASSTD EA	Prior authorization is required when the billed charges are greater than $500.		
E0118	CRUTCH SUBSTITUTE LW LEG PLATFORM	Prior authorization is required when the billed charges are greater than $500.		
E0130	WALKER RIGID ADJUSTBLE/FIXED HEIGHT	Prior authorization is required when the billed charges are greater than $500.		
E0135	WALKER FOLDING ADJUSTBLE/FIX HEIGHT	Prior authorization is required when the billed charges are greater than $500.		
E0140	WALK W/TRNK SUPP ADJUSTBL/FIX HT	Prior authorization is required when the billed charges are greater than $500.		
E0141	WALKER RIGID WHEELD ADJUSTBL/FIX HT	Prior authorization is required when the billed charges are greater than $500.		
E0143	WALKER FOLD WHEELED ADJUSTBL/FIX HT	Prior authorization is required when the billed charges are greater than $500.		
E0144	WALKER ENCLOS 4 SIDE WHL POST SEAT	Prior authorization is required when the billed charges are greater than $500.		
E0147	WALKR HEVY DUTY MX BRAKE VARIBL WHL	Prior authorization is required when the billed charges are greater than $500.		
E0148	WALK HEVY DUTY NO WHLS RIGD/FOLD EA	Prior authorization is required when the billed charges are greater than $500.		
E0149	WALKER HEVY DUTY WHEELD ANY TYPE EA	Prior authorization is required when the billed charges are greater than $500.		
E0153	PLATFORM ATTCH FOREARM CRUTCH EA	Prior authorization is required when the billed charges are greater than $500.		
E0154	PLATFORM ATTACHMENT WALKER EACH	Prior authorization is required when the billed charges are greater than $500.		
E0155	WHL ATTCH PCK-UP WLK- PER PAIR SEAT	Prior authorization is required when the billed charges are greater than $500.		

E0156	SEAT ATTACHMENT WALKER	Prior authorization is required when the billed charges are greater than $500.		
E0157	CRUTCH ATTACHMENT WALKER EACH	Prior authorization is required when the billed charges are greater than $500.		
E0158	LEG EXTENSIONS WALKER PER SET FOUR	Prior authorization is required when the billed charges are greater than $500.		
E0159	BRAKE ATTCH WHEELED WALK REPLCMT EA	Prior authorization is required when the billed charges are greater than $500.		
E0160	SITZ BATH/EQP PRTBLE W/WO COMMODE	Prior authorization is required when the billed charges are greater than $500.		
E0161	SITZ BATH/EQP PRTBLE USED W/FAUCET	Prior authorization is required when the billed charges are greater than $500.		
E0162	SITZ BATH CHAIR	Prior authorization is required when the billed charges are greater than $500.		
E0163	COMMODE CHAIR WITH FIXED ARMS	Prior authorization is required when the billed charges are greater than $500.		
E0165	COMMODE CHAIR WITH DETACHABLE ARMS	Prior authorization is required when the billed charges are greater than $500.		
E0167	PAIL/PAN USE W/COMMODE CHAIR REPL	Prior authorization is required when the billed charges are greater than $500.		
E0168	COMMODE CHAIR XTRA WIDE&/HEVY DUTY	Prior authorization is required when the billed charges are greater than $500.		
E0170	COMMODE CHAIR SEAT LIFT MECH ELEC	Prior authorization is required when the billed charges are greater than $500.		
E0171	COMMODE CHAIR SEAT LIFT MCH NONELEC	Prior authorization is required when the billed charges are greater than $500.		
E0172	SEAT LIFT MECH PLACE OVR/TOP TOILET	Prior authorization is required when the billed charges are greater than $500.		
E0175	FOOT REST USE W/COMMODE CHAIR EACH	Prior authorization is required when the billed charges are greater than $500.		
E0181	Powered pressure reducing mattress overlay/pad, alternating, with pump, includes heavy-duty	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items	
E0182	PUMP ALTERNATING PRESSURE PAD REPL	Prior authorization is required when the billed charges are greater than $500.		
E0183	PWR PRESS RDUC UNDRLAY/PAD ALT PUMP	Prior authorization is required when the billed charges are greater than $500.		
E0184	Dry pressure mattress	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items	
E0185	Gel or gel-like pressure pad for mattress, standard mattress length and width	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items	
E0186	Air pressure mattress	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items	
E0187	Water pressure mattress	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items	
E0188	SYNTHETIC SHEEPSKIN PAD	Prior authorization is required when the billed charges are greater than $500.		
E0189	LAMBSWOOL SHEEPSKIN PAD ANY SIZE	Prior authorization is required when the billed charges are greater than $500.		
E0190	PSTN CUSH/PILLOW/EDGE ALL COMPONENT	Prior authorization is required when the billed charges are greater than $500.		
E0191	HEEL OR ELBOW PROTECTOR EACH	Prior authorization is required when the billed charges are greater than $500.		
E0193	Powered air flotation bed (low air loss therapy)	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items	
E0194	Air fluidized bed	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items	
E0196	Gel pressure mattress	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items	
E0197	Air pressure pad for mattress, standard mattress length and width	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items	
E0198	Water pressure pad for mattress, standard mattress length and width	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items	
E0199	Dry pressure pad for mattress, standard mattress length and width	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items	
E0200	HEAT LAMP W/O STAND W/INFRARD ELEM	Prior authorization is required when the billed charges are greater than $500.		
E0202	PHOTOTHERAPY LIGHT WITH PHOTOMETER	Prior authorization is required when the billed charges are greater than $500.		
E0203	TX LTBOX MINI 10000 LUX TABLE TOP	Prior authorization is required when the billed charges are greater than $500.		
E0205	HEAT LAMP W/STAND W/INFRARD ELEM	Prior authorization is required when the billed charges are greater than $500.		
E0210	ELECTRIC HEAT PAD STANDARD	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1246 Home Dialysis Equipment and Supplies	
E0215	ELECTRIC HEAT PAD MOIST	Prior authorization is required when the billed charges are greater than $500.		
E0217	WATER CIRCULATING HEAT PAD W/PUMP	Prior authorization is required when the billed charges are greater than $500.		
E0218	FLUID CIRC COLD PAD W/PUMP ANY TYPE	Prior authorization is required when the billed charges are greater than $500.		
E0221	INFRARED HEATING PAD SYSTEM	Prior authorization is required when the billed charges are greater than $500.		
E0225	HYDROCOLLATOR UNIT INCLUDES PADS	Prior authorization is required when the billed charges are greater than $500.		
E0231	NON-CNTC WND WARM DEVC W/CARD&COVR	Prior authorization is required when the billed charges are greater than $500.		
E0232	WOUND WARMING WOUND COVER	Prior authorization is required when the billed charges are greater than $500.		
E0235	PARAFFIN BATH UNIT PORTABLE	Prior authorization is required when the billed charges are greater than $500.		
E0236	PUMP FOR WATER CIRCULATING PAD	Prior authorization is required when the billed charges are greater than $500.		
E0239	HYDROCOLLATOR UNIT PORTABLE	Prior authorization is required when the billed charges are greater than $500.		
E0240	BATH/SHOWER CHAIR W/WO WHLS ANY SZ	Prior authorization is required when the billed charges are greater than $500.		
E0241	BATHTUB WALL RAIL EACH	Prior authorization is required when the billed charges are greater than $500.		
E0242	BATHTUB RAIL FLOOR BASE	Prior authorization is required when the billed charges are greater than $500.		
E0243	TOILET RAIL EACH	Prior authorization is required when the billed charges are greater than $500.		
E0244	RAISED TOILET SEAT	Prior authorization is required when the billed charges are greater than $500.		
E0245	TUB STOOL OR BENCH	Prior authorization is required when the billed charges are greater than $500.		
E0246	TRANSFER TUB RAIL ATTACHMENT	Prior authorization is required when the billed charges are greater than $500.		
E0247	TRNSF BENCH TUB/TOILET W/WO COMMODE	Prior authorization is required when the billed charges are greater than $500.		
E0248	TRNSF BENCH HEVY DUTY TUB/TOILET	Prior authorization is required when the billed charges are greater than $500.		
E0249	PAD H2O CIRC HEAT UNIT REPLCMT ONLY	Prior authorization is required when the billed charges are greater than $500.		

E0250	Hospital bed, fixed height, with any type side rails, with mattress	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items	
E0251	Hospital bed, fixed height, with any type side rails, without mattress	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items	
E0255	Hospital bed, variable height, hi-lo, with any type side rails, with mattress	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items	
E0256	Hospital bed, variable height, hi-lo, with any type side rails, without mattress	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items	
E0260	Hospital bed, semi-electric (head and foot adjustment), with any type side rails, with mattress	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items	
E0261	Hospital bed, semi-electric (head and foot adjustment), with any type side rails, without mattress	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items	
E0265	Hospital bed, total electric (head, foot and height adjustments), with any type side rails, with mattress	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items	
E0266	Hospital bed, total electric (head, foot and height adjustments), with any type side rails, without mattress	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items	
E0270	HOSP BED INST TYPE: W/MATTRSS	Prior authorization is required when the billed charges are greater than $500.		
E0271	Mattress, innerspring	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items	
E0272	Mattress, foam rubber	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items	
E0273	Bed board	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items	
E0274	Over-bed table	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items	
E0275	Bed pan, standard, metal or plastic	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items	
E0276	Bed pan, fracture, metal or plastic	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items	
E0277	Powered pressure-reducing air mattress	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items	
E0280	Bed cradle, any type	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items	
E0290	Hospital bed, fixed height, without side rails, with mattress	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items	
E0291	Hospital bed, fixed height, without side rails, without mattress	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items	
E0292	Hospital bed, variable height, hi-lo, without side rails, with mattress	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items	
E0293	Hospital bed, variable height, hi-lo, without side rails, without mattress	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items	
E0294	Hospital bed, semi-electric (head and foot adjustment), without side rails, with mattress	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items	
E0295	Hospital bed, semi-electric (head and foot adjustment), without side rails, without mattress	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items	
E0296	Hospital bed, total electric (head, foot and height adjustments), without side rails, with mattress	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items	
E0297	Hospital bed, total electric (head, foot and height adjustments), without side rails, without mattress	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items	
E0300	Pediatric crib, hospital grade, fully enclosed, with or without top enclosure	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items	
E0301	Hospital bed, heavy-duty, extra wide, with weight capacity greater than 350 pounds, but less than or equal to 600 pounds, with any type side rails, without mattress	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items	
E0302	Hospital bed, extra heavy-duty, extra wide, with weight capacity greater than 600 pounds, with any type side rails, without mattress	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items	
E0303	Hospital bed, heavy-duty, extra wide, with weight capacity greater than 350 pounds, but less than or equal to 600 pounds, with any type side rails, with mattress	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items	
E0304	Hospital bed, extra heavy-duty, extra wide, with weight capacity greater than 600 pounds, with any type side rails, with mattress	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items	
E0305	Bedside rails, half-length	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items	
E0310	Bedside rails, full-length	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items	
E0315	BED ACCESS: BOARD/TABL/SUPPRT DEVC	Prior authorization is required when the billed charges are greater than $500.		
E0316	Safety enclosure frame/canopy for use with hospital bed, any type	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items	
E0325	URINAL; MALE JUG-TYPE ANY MATERIAL	Prior authorization is required when the billed charges are greater than $500.		
E0326	URINAL; FE JUG-TYPE ANY MATERIAL	Prior authorization is required when the billed charges are greater than $500.		
E0328	Hospital bed, pediatric, manual, 360 degree side enclosures, top of headboard, footboard and side rails up to 24 in above the spring, includes mattress	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items	

E0329	Hospital bed, pediatric, electric or semi-electric, 360 degree side enclosures, top of headboard, footboard and side rails up to 24 in above the spring, includes mattress	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items	
E0350	CNTRL U ELEC BOWEL IRRIG/EVAC SYS	Prior authorization is required when the billed charges are greater than $500.		
E0352	DISPBL PACK W/ELEC BOWEL IRRIG/EVAC	Prior authorization is required when the billed charges are greater than $500.		
E0370	AIR PRESSURE ELEVATOR FOR HEEL	Prior authorization is required when the billed charges are greater than $500.		
E0371	Nonpowered advanced pressure reducing overlay for mattress, standard mattress length and width	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items	
E0372	Powered air overlay for mattress, standard mattress length and width	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items	
E0373	Nonpowered advanced pressure reducing mattress	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items	
E0424	STATION COMPRS GASOUS O2 SYS RENT;	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1072 Oxygen	
E0425	STATION COMPRS GAS SYS PURCHASE;	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1072 Oxygen	
E0430	PRTBLE GASEOUS O2 SYS PURCHASE;	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1072 Oxygen	
E0431	PRTBLE GASEOUS O2 SYS RENTAL;	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1072 Oxygen	
E0433	PORTBL LIQ O2 SYS RENT; HOME LIQUIF	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1072 Oxygen	
E0434	PRTBLE LIQUID O2 SYS RENTAL;	Prior authorization is required when the billed charges are greater than $500.		
E0435	PRTBLE LIQUID O2 SYS PURCHASE;	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1072 Oxygen	
E0439	STATION LIQUID O2 SYS RENTAL;	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1072 Oxygen	
E0440	STATION LIQUID O2 SYS PURCHASE;	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1072 Oxygen and HHO-DE-MP-1030 Home Oxygen Therapy	
E0441	STATIONARY O2 CONT GAS 1 MO SPL=1 U	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1072 Oxygen and HHO-DE-MP-1030 Home Oxygen Therapy	
E0442	STATIONARY 02 CONT LQD 1 MO SPL=1 U	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1072 Oxygen and HHO-DE-MP-1030 Home Oxygen Therapy	
E0443	PORTBL O2 CONTENT GAS 1 MO SPL= 1 U	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1072 Oxygen and HHO-DE-MP-1030 Home Oxygen Therapy	
E0444	PORTBL O2 CONTENT LIQ 1 MO SPL=1 U	Prior authorization is required when the billed charges are greater than $500.		
E0445	OXIMETER MSR BLD O2 LEVL NON-INVASV	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1072 Oxygen, Home Pulse Oximetry Devices HHO-DE-MP-1079 and HHO-DE-MP-1030 Home Oxygen Therapy	
E0446	Topical oxygen delivery system, not otherwise specified, includes all supplies and accessories	Prior authorization is required for billed charges greater than $500.		
E0447	P O C L 1M SPL=1U PRSC R/N XCD 4LPM	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1072 Oxygen and HHO-DE-MP-1030 Home Oxygen Therapy	
E0455	O2 TENT EXCLD CROUP/PEDIATRIC TENTS	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1030 Home Oxygen Therapy	
E0457	CHEST SHELL	Prior authorization is required when the billed charges are greater than $500.		
E0459	CHEST WRAP	Prior authorization is required when the billed charges are greater than $500.		
E0462	ROCKING BED W/WO SIDE RAILS	Prior authorization is required when the billed charges are greater than $500.		
E0465	HOME VENT ANY TYPE USED INVASV INTF	Prior authorization is required when the billed charges are greater than $500.		
E0466	HOME VENT TYPE USED NON-INVASV INTF	Prior authorization is required when the billed charges are greater than $500.		
E0467	HOME VENTILATOR MULTI-FUNC RESP DVC	Prior authorization is required when the billed charges are greater than $500.		
E0470	Respiratory assist device, bi-level pressure capability, without backup rate feature, used with noninvasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device)	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1063 Devices Used for the Treatment of Obstructive Sleep Apnea in Adults and HHO-DE-MP-1076 Respiratory Assist Devices	
E0471	Respiratory assist device, bi-level pressure capability, with back-up rate feature, used with noninvasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device)	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1063 Devices Used for the Treatment of Obstructive Sleep Apnea in Adults and HHO-DE-MP-1076 Respiratory Assist Devices	
E0472	Respiratory assist device, bi-level pressure capability, with backup rate feature, used with invasive interface, e.g., tracheostomy tube (intermittent assist device with continuous positive airway pressure device)	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1076 Respiratory Assist Devices	
E0480	PERCUSSOR ELEC/PNEUMAT HOME MODEL	Prior authorization is required when the billed charges are greater than $500.		
E0481	INTRAPULM PERCUSS VENT SYS&REL ACSS	Prior authorization is required when the billed charges are greater than $500.		
E0482	COUGH STIM DEVC ALTRNAT POS&NEG	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1141 High Frequency Chest Wall Oscillation Devices	
E0483	HF CW OS SYS TH REG REC SIM EX OS Q	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1141 High Frequency Chest Wall Oscillation Devices	
E0484	OSCILLAT POS EXPIRTORY PRSS NO-ELEC	Prior authorization is required when the billed charges are greater than $500.		
E0485	Oral device/appliance used to reduce upper airway collapsibility, adjustable or nonadjustable, prefabricated, includes fitting and adjustment	Prior authorization is required when the billed charge is greater than $500. Reference policies for additional information.	HHO-DE-MP-1065 Diagnosis and Treatment of Obstructive Sleep Apnea in Pediatric individuals and HHO-DE-MP-1063 Devices Used for the Treatment of Obstructive Sleep Apnea in Adults	

E0486	Oral device/appliance used to reduce upper airway collapsibility, adjustable or nonadjustable, custom fabricated, includes fitting and adjustment	Prior authorization is required when the billed charge is greater than $500. Reference policies for additional information.	HHO-DE-MP-1065 Diagnosis and Treatment of Obstructive Sleep Apnea in Pediatric individuals and HHO-DE-MP-1063 Devices Used for the Treatment of Obstructive Sleep Apnea in Adults	
E0487	SPIROMETER ELECTRONIC INCL ACCESS	Prior authorization is required when the billed charges are greater than $500.		
E0500	IPPB MACH BUILT-IN NEBULZ;VALVS;PWR	Prior authorization is required when the billed charges are greater than $500.		
E0550	HUMDIFR EXT SUPLMNTL DUR IPPB TX/O2	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1072 Oxygen and HHO-DE-MP-1030 Home Oxygen Therapy	
E0555	HUMDIFR GLASS/AUTOCLVBL PLSTC BOTTL	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1030 Home Oxygen Therapy	
E0560	HUMDIFIR SUPLMNTL DUR IPPB TX/O2	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1072 Oxygen and HHO-DE-MP-1030 Home Oxygen Therapy	
E0561	Humidifier, nonheated, used with positive airway pressure device	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1063 Devices Used for the Treatment of Obstructive Sleep Apnea in Adults and HHO-DE-MP-1076 Respiratory Assist Devices	
E0562	Humidifier, heated, used with positive airway pressure device	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1063 Devices Used for the Treatment of Obstructive Sleep Apnea in Adults and HHO-DE-MP-1076 Respiratory Assist Devices	
E0565	COMPRS AIR PWR EQP NOT SLF-CONTAIND	Prior authorization is required when the billed charges are greater than $500.		
E0570	NEBULIZER WITH COMPRESSOR	Prior authorization is required when the billed charges are greater than $500.		
E0572	AROSL COMPRS ADJSTBL PRSS INTERMIT	Prior authorization is required when the billed charges are greater than $500.		
E0574	US/ELEC AROSL GEN W/SM VOLUME NEB	Prior authorization is required when the billed charges are greater than $500.		
E0575	NEBULIZER ULTRASONIC LARGE VOLUME	Prior authorization is required when the billed charges are greater than $500.		
E0580	NEBULIZR GLASS/AUTOCLVBL PLST BOTTL	Prior authorization is required when the billed charges are greater than $500.		
E0585	NEBULIZER W/COMPRESSOR AND HEATER	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1072 Oxygen and HHO-DE-MP-1030 Home Oxygen Therapy	
E0600	Respiratory suction pump, home model, portable or stationary, electric	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1063 Devices Used for the Treatment of Obstructive Sleep Apnea in Adults	
E0601	Continuous positive airway pressure (CPAP) device	Prior authorization is required when the billed charge is greater than $500. Reference policies for additional information.	HHO-DE-MP-1065 Diagnosis and Treatment of Obstructive Sleep Apnea in Pediatric individuals and HHO-DE-MP-1063 Devices Used for the Treatment of Obstructive Sleep Apnea in Adults	
E0603	BREAST PUMP ELECTRIC ANY TYPE	Prior authorization is required when the billed charges are greater than $500.		
E0604	Breast pump, hospital grade, electric (AC and/or DC), any type	Prior authorization is required.		
E0605	VAPORIZER ROOM TYPE	Prior authorization is required when the billed charges are greater than $500.		
E0606	POSTURAL DRAINAGE BOARD	Prior authorization is required when the billed charges are greater than $500.		
E0607	HOME BLOOD GLUCOSE MONITOR	Prior authorization is required when the billed charges are greater than $500.		
E0610	PACEMKR MON CHCK BATTRY AUDBL&VISBL	Prior authorization is required when the billed charges are greater than $500.		
E0615	PACEMKR MON CHCK BATTRY DIGTL/VISBL	Prior authorization is required when the billed charges are greater than $500.		
E0616	IMPL CARD EVNT REC MEM ACTVTR&PRGMR	Prior authorization is required when the billed charges are greater than $500.		
E0617	EXT DEFIB W/INTEGRATED ECG ANALY	Prior authorization is required when the billed charges are greater than $500.		
E0618	Apnea monitor, without recording feature	Prior authorization is required when the billed charge is greater than $500. Reference policies for additional information.	HHO-DE-MP-1065 Diagnosis and Treatment of Obstructive Sleep Apnea in Pediatric individuals	
E0619	Apnea monitor, with recording feature	Prior authorization is required when the billed charge is greater than $500. Reference policies for additional information.	HHO-DE-MP-1065 Diagnosis and Treatment of Obstructive Sleep Apnea in Pediatric individuals	
E0620	SKN PIERC DEVC CLCT CAPLRY BLD LASR	Prior authorization is required when the billed charges are greater than $500.		
E0621	SLING/SEAT PT LIFT CANVAS/NYLON	Prior authorization is required when the billed charges are greater than $500.		
E0625	Patient lift, bathroom or toilet, not otherwise classified	Prior authorization is required for billed charges greater than $500.		
E0627	SEAT LIFT MECH COMB LIFT-CHAIR MECH	Prior authorization is required when the billed charges are greater than $500.		
E0629	SEAT LIFT MECH NON-ELECTRIC ANY TYP	Prior authorization is required when the billed charges are greater than $500.		
E0630	PATIENT LIFT HYRAULIC/MECH	Prior authorization is required when the billed charges are greater than $500.		
E0635	PATIENT LIFT ELECTRIC W/SEAT/SLING	Prior authorization is required when the billed charges are greater than $500.		
E0636	MX PSTN PT SUPP SYS LIFT PT CNTRL	Prior authorization is required when the billed charges are greater than $500.		
E0637	COMB SIT STAND FRAME/TABLE SEATLIFT	Prior authorization is required when the billed charges are greater than $500.		
E0638	STAND FRAME/TABLE SYS 1 POS ANY SZ	Prior authorization is required when the billed charges are greater than $500.		
E0639	PT LIFT MOVEABLE DISASSMBL&REASSMBL	Prior authorization is required when the billed charges are greater than $500.		
E0640	PT LIFT FIX SYS ALL CMPNTS/ACCESS	Prior authorization is required when the billed charges are greater than $500.		
E0641	STAND FRAME/TABLE SYS MX-POS ANY SZ	Prior authorization is required when the billed charges are greater than $500.		
E0642	STAND FRAME/TABLE SYS MOBILE ANY SZ	Prior authorization is required when the billed charges are greater than $500.		
E0650	PNEUMAT COMPRS NONSEG HOME MODEL	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1144 Pneumatic Compression Devices	
E0651	PNEUMAT COMPRS NO CALBRT GRDNT PRSS	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1144 Pneumatic Compression Devices	
E0652	PNEUMAT COMPRS W/CALBRT GRADNT PRSS	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1144 Pneumatic Compression Devices	
E0655	NONSEG PNEUMAT APPLINC HALF ARM	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1144 Pneumatic Compression Devices	
E0656	SEG PNEUMAT APPLINC W/COMPRS TRUNK	Prior authorization is required when the billed charges are greater than $500.		

E0657	SEG PNEUMAT APPLINC W/COMPRS CHEST	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1144 Pneumatic Compression Devices	
E0660	NONSEG PNEUMAT APPLINC FULL LEG	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1144 Pneumatic Compression Devices	
E0665	NONSEG PNEUMAT APPLINC FULL ARM	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1144 Pneumatic Compression Devices	
E0666	NONSEG PNEUMAT APPLINC HALF LEG	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1144 Pneumatic Compression Devices	
E0667	SEG PNEUMAT APPLINC COMPRS FULL LEG	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1144 Pneumatic Compression Devices	
E0668	SEG PNEUMAT APPLINC COMPRS FULL ARM	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1144 Pneumatic Compression Devices	
E0669	SEG PNEUMAT APPLINC COMPRS HALF LEG	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1144 Pneumatic Compression Devices	
E0670	SEG PNEU APPL P C INT 2 F LEG TRNK	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1144 Pneumatic Compression Devices	
E0671	SEG GRAD PRSS PNUMAT APPLNC FUL LEG	Prior authorization is required when the billed charges are greater than $500.		
E0672	SEG GRAD PRSS PNUMAT APPLNC FUL ARM	Prior authorization is required when the billed charges are greater than $500.		
E0673	SEG GRAD PRSS PNUMAT APPLNC HLF LEG	Prior authorization is required when the billed charges are greater than $500.		
E0675	PNEUMAT COMPRS DEVC HI PRESS RAPID	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1144 Pneumatic Compression Devices	
E0676	INTERMITT LIMB COMPRESSION DEVC NOS	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1144 Pneumatic Compression Devices	
E0678	Non-pneumatic sequential compression garment, full leg	Prior authorization is required when the billed charges are greater than $500.		
E0679	Non-pneumatic sequential compression garment, half leg	Prior authorization is required when the billed charges are greater than $500.		
E0680	Non-pneumatic compression controller with sequential calibrated gradient pressure	Prior authorization is required when the billed charges are greater than $500.		
E0681	Non-pneumatic compression controller without calibrated gradient pressure	Prior authorization is required when the billed charges are greater than $500.		
E0682	Non-pneumatic sequential compression garment, full arm	Prior authorization is required when the billed charges are greater than $500.		
E0691	UV LIGHT TX BULB/LAMP; TX 2 SQ FT/<	Prior authorization is required when the billed charges are greater than $500.		
E0692	UV LT TX SYS PANL W/LAMP 4 FT PANEL	Prior authorization is required when the billed charges are greater than $500.		
E0693	UV LT TX SYS PANL W/LAMP 6 FT PANEL	Prior authorization is required when the billed charges are greater than $500.		
E0694	UV MX DIR LT TX SYS 6 FT CABINET	Prior authorization is required when the billed charges are greater than $500.		
E0700	SAFETY EQP DEVICE/ACCESSRY ANY TYPE	Prior authorization is required when the billed charges are greater than $500.		
E0705	TRANSFER DEVICE ANY TYPE EACH	Prior authorization is required when the billed charges are greater than $500.		
E0710	RESTRAINT ANY TYPE	Prior authorization is required when the billed charges are greater than $500.		
E0720	Transcutaneous electrical nerve stimulation (TENS) device, two-lead, localized stimulation	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1136 Temporomandibular Joint Dysfunction	
E0730	Transcutaneous electrical nerve stimulation (TENS) device, four or more leads, for multiple nerve stimulation	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1136 Temporomandibular Joint Dysfunction	
E0731	Form-fitting conductive garment for delivery of TENS or NMES (with conductive fibers separated from the patient's skin by layers of fabric)	Prior authorization is required for billed charges greater than $500.		
E0740	N-IMPL PELV FLR ELEC STIM CMPL SYS	Prior authorization is required when the billed charges are greater than $500.		
E0744	NEUROMUSCULAR STIMULATOR SCOLIOSIS	Prior authorization is required when the billed charges are greater than $500.		
E0745	Neuromuscular stimulator, electronic shock unit	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1185 Functional Neuromuscular Electrical Stimulation and Other Electrical Stimulator	
E0746	ELECTROMYOGRAPHY BIOFEEDBACK DEVICE	Prior authorization is required when the billed charges are greater than $500.		
E0747	Osteogenesis stimulator, electrical, noninvasive, other than spinal applications	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1251 Ultrasound Osteogenesis Stimulator and HHO-DE-MP-1149 Non-Spinal Bone Growth Stimulation	
E0748	Osteogenesis stimulator, electrical, noninvasive, spinal applications	Prior authorization is managed by EviCore for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1148 Electrical Bone Growth Stimulation Spinal	Prior authorization is managed by EviCore.
E0749	Osteogenesis stimulator, electrical, surgically implanted	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
E0755	ELEC SALIVARY REFLEX STIMULATOR	Prior authorization is required when the billed charges are greater than $500.		
E0760	Osteogenesis stimulator, low intensity ultrasound, noninvasive	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1251 Ultrasound Osteogenesis Stimulator	
E0761	NON-THRML PULS RADIOWAVE ELECMAGNET	Prior authorization is required when the billed charges are greater than $500.		
E0762	TRANSCUT ELEC JOINT STIM DEVC SYS	Prior authorization is required when the billed charges are greater than $500.		
E0764	Functional neuromuscular stimulation, transcutaneous stimulation of sequential muscle groups of ambulation with computer control, used for walking by spinal cord injured, entire system, after completion of training program	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1185 Functional Neuromuscular Electrical Stimulation and Other Electrical Stimulator	
E0765	FDA APPRVD NRV STIM TX NAUSA&VOMIT	Prior authorization is required when the billed charges are greater than $500.		
E0766	Electrical stimulation device used for cancer treatment, includes all accessories, any type	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1244 Tumor Treatment fields	
E0769	Electrical stimulation or electromagnetic wound treatment device, not otherwise classified	Prior authorization is required for billed charges greater than $500.		
E0770	Functional electrical stimulator, transcutaneous stimulation of nerve and/or muscle groups, any type, complete system, not otherwise specified	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1185 Functional Neuromuscular Electrical Stimulation and Other Electrical Stimulator	
E0776	IV POLE	Prior authorization is required when the billed charges are greater than $500.		

E0779	Ambulatory infusion pump, mechanical, reusable, for infusion 8 hours or greater	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1134 Portable External Infusion Pump	
E0780	Ambulatory infusion pump, mechanical, reusable, for infusion less than 8 hours	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1134 Portable External Infusion Pump	
E0781	Ambulatory infusion pump, single or multiple channels, electric or battery operated, with administrative equipment, worn by patient	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1134 Portable External Infusion Pump	
E0782	INFUS PUMP IMPL NON-PROGMMABLE	Prior authorization is required when the billed charges are greater than $500.		
E0783	INFUS PUMP SYSTEM IMPL PROGMMABLE	Prior authorization is required when the billed charges are greater than $500.		
E0784	EXTERNAL AMB INFUSION PUMP INSULIN	Prior authorization is required when the billed charges are greater than $500.		
E0785	IMPLANT INTRASPINL CATH PUMP-REPL	Prior authorization is required when the billed charges are greater than $500.		
E0786	IMPLNT PROGRAM INFUSION PUMP-REPL	Prior authorization is required when the billed charges are greater than $500.		
E0787	EXT AMB INFUS PUMP INSULIN D R ADJ	Prior authorization is required when the billed charges are greater than $500.		
E0791	Parenteral infusion pump, stationary, single, or multichannel	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1134 Portable External Infusion Pump	
E0830	AMB TRACTION DEVICE ALL TYPES EACH	Prior authorization is required when the billed charges are greater than $500.		
E0840	TRACTION FRAME HEADBOARD CERV TRACT	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1245 Home Cervical Traction Therapy	
E0849	TRAC EQP CERV FREESTND FRME PNEUMAT	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1245 Home Cervical Traction Therapy	
E0850	TRACT STAND FREESTAND CERV TRACT	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1245 Home Cervical Traction Therapy	
E0855	CERV TRACT EQUIP NOT RQR ADD STAND	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1245 Home Cervical Traction Therapy	
E0856	CERVICAL TRAC DEVC INFL AIR BLADDER	Prior authorization is required when the billed charges are greater than $500.		
E0860	TRACTION EQUIPMENT OVERDOOR CERV	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1245 Home Cervical Traction Therapy	
E0870	TRACT FRAME FOOTBOARD EXTREM TRACT	Prior authorization is required when the billed charges are greater than $500.		
E0880	TRACTION STAND FS EXTREMITY TRACTN	Prior authorization is required when the billed charges are greater than $500.		
E0890	TRAC FRAME ATTCH FOOTBRD PELV TRAC	Prior authorization is required when the billed charges are greater than $500.		
E0900	TRACT STAND FREESTAND PELV TRACT	Prior authorization is required when the billed charges are greater than $500.		
E0910	Trapeze bars, also known as Patient Helper, attached to bed, with grab bar	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items	
E0911	Trapeze bar, heavy-duty, for patient weight capacity greater than 250 pounds, attached to bed, with grab bar	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items	
E0912	Trapeze bar, heavy-duty, for patient weight capacity greater than 250 pounds, freestanding, complete with grab bar	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items	
E0920	FX FRAME ATTCH BED INCL WEIGHTS	Prior authorization is required when the billed charges are greater than $500.		
E0930	FX FRAME FREESTANDING INCL WEIGHTS	Prior authorization is required when the billed charges are greater than $500.		
E0935	CONT PSV MOT EXER DEVC KNEE ONLY	Prior authorization is required when the billed charges are greater than $500.		
E0936	CONT PASS MOTION EXER DEVC NOT KNEE	Prior authorization is required when the billed charges are greater than $500.		
E0940	Trapeze bar, freestanding, complete with grab bar	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items	
E0941	GRAVITY ASSTD TRAC DEVICE ANY TYPE	Prior authorization is required when the billed charges are greater than $500.		
E0942	CERVICAL HEAD HARNESS/HALTER	Prior authorization is required when the billed charges are greater than $500.		
E0944	PELVIC BELT/HARNESS/BOOT	Prior authorization is required when the billed charges are greater than $500.		
E0945	EXTREMITY BELT/HARNESS	Prior authorization is required when the billed charges are greater than $500.		
E0946	FX FRAM DUAL CROSS BARS ATTACH BED	Prior authorization is required when the billed charges are greater than $500.		
E0947	FX FRAME ATTCH CMPLX PELV TRAC	Prior authorization is required when the billed charges are greater than $500.		
E0948	FX FRAME ATTCH CMPLX CERV TRAC	Prior authorization is required when the billed charges are greater than $500.		
E0950	WHEELCHAIR ACCESSORY TRAY EACH	Prior authorization is required when the billed charges are greater than $500.		
E0951	HEEL LOOP/HOLDER ANY TYPE EACH	Prior authorization is required when the billed charges are greater than $500.		
E0952	TOE LOOP/HOLDER ANY TYPE EACH	Prior authorization is required when the billed charges are greater than $500.		
E0953	WC AC LAT THIGH/KNEE SUPP ANY TY EA	Prior authorization is required when the billed charges are greater than $500.		
E0954	WHEELCHAIR AC FOOT BOX ANY TY EA FT	Prior authorization is required when the billed charges are greater than $500.		
E0955	WC ACSS HEADREST CUSHND HARDWARE EA	Prior authorization is required when the billed charges are greater than $500.		
E0956	WC ACSS LAT TRNK/HIP HARDWARE EA	Prior authorization is required when the billed charges are greater than $500.		
E0957	WC ACSS MED THI SUPP HARDWARE EA	Prior authorization is required when the billed charges are greater than $500.		
E0958	MNL WC ACCESS 1-ARM DRIVE ATTCH EA	Prior authorization is required when the billed charges are greater than $500.		
E0959	MNL WC ACCSS ADAPTER FOR AMPUTEE EA	Prior authorization is required when the billed charges are greater than $500.		
E0960	WC ACSS SHLDR HRNSS/STRAPS/CHST STR	Prior authorization is required when the billed charges are greater than $500.		
E0961	MNL WC ACCESS WHL LOCK BRAKE EXT EA	Prior authorization is required when the billed charges are greater than $500.		
E0966	MNL WC ACCESS HEADREST EXTENSION EA	Prior authorization is required when the billed charges are greater than $500.		
E0967	MNL WC AC HND RIM PROJ REPL ONL EA	Prior authorization is required when the billed charges are greater than $500.		
E0968	COMMODE SEAT WHEELCHAIR	Prior authorization is required when the billed charges are greater than $500.		
E0969	NARROWING DEVICE WHEELCHAIR	Prior authorization is required when the billed charges are greater than $500.		
E0970	NO 2 FOOTPLATES EXCEPT ELEV LEGREST	Prior authorization is required when the billed charges are greater than $500.		
E0971	MNL WC ACSS ANTI-TIPPING DEVC EA	Prior authorization is required when the billed charges are greater than $500.		
E0973	WC ACCSS ADJ HT DTACH ARMRST EA	Prior authorization is required when the billed charges are greater than $500.		
E0974	MNL WC ACCESS ANTI-ROLLBACK DEVC EA	Prior authorization is required when the billed charges are greater than $500.		

E0978	WC ACSS PSTN/SFTY BELT/PELV STRP EA	Prior authorization is required when the billed charges are greater than $500.		
E0980	SAFETY VEST WHEELCHAIR	Prior authorization is required when the billed charges are greater than $500.		
E0981	WC ACSS SEAT UPHLSTER REPL ONLY EA	Prior authorization is required when the billed charges are greater than $500.		
E0982	WC ACSS BACK UPHLSTER REPL ONLY EA	Prior authorization is required when the billed charges are greater than $500.		
E0983	MNL WC ACSS PWR ADD-ON CNVRT MNL WC	Prior authorization is required when the billed charges are greater than $500.		
E0984	MNL WC ACSS PWR ADD-ON CNVRT MNL WC	Prior authorization is required when the billed charges are greater than $500.		
E0985	WHEELCHAIR ACCESS SEAT LIFT MECH	Prior authorization is required when the billed charges are greater than $500.		
E0986	MNL WC ACSS PSH-RM ACT PWR ASST SYS	Prior authorization is required when the billed charges are greater than $500.		
E0988	MNL WC ACSS LEVR-ACT WHL DRIVE PAIR	Prior authorization is required when the billed charges are greater than $500.		
E0990	WC ACCSS ELEV LEG REST CMPL ASSMBL	Prior authorization is required when the billed charges are greater than $500.		
E0992	MNL WHLCHAIR ACCSS SOLID SEAT INSRT	Prior authorization is required when the billed charges are greater than $500.		
E0994	ARMREST EACH	Prior authorization is required when the billed charges are greater than $500.		
E0995	WC AC CALF REST/PAD REPL ONLY EA	Prior authorization is required when the billed charges are greater than $500.		
E1002	WC ACSS PWR SEATING SYS TILT ONLY	Prior authorization is required when the billed charges are greater than $500.		
E1003	WC ACSS RECLINE ONLY NO SHEAR RDUC	Prior authorization is required when the billed charges are greater than $500.		
E1004	WC ACSS RECLINE W/MECH SHEAR RDUC	Prior authorization is required when the billed charges are greater than $500.		
E1005	WC ACSS RECLINE W/PWR SHEAR RDUC	Prior authorization is required when the billed charges are greater than $500.		
E1006	WC ACSS TILT&RECLINE NO SHEAR RDUC	Prior authorization is required when the billed charges are greater than $500.		
E1007	WC ACSS TILT&RECLIN MECH SHEAR RDUC	Prior authorization is required when the billed charges are greater than $500.		
E1008	WC ACSS TILT&RECLINE PWR SHEAR RDUC	Prior authorization is required when the billed charges are greater than $500.		
E1009	WC ACCSS MECH LINKD LEG ELEV EA	Prior authorization is required when the billed charges are greater than $500.		
E1010	WC ACCSS PWR LEG ELEV SYS PAIR	Prior authorization is required when the billed charges are greater than $500.		
E1011	MOD PED SIZE WC WIDTH ADJ PACKAGE	Prior authorization is required when the billed charges are greater than $500.		
E1012	WC ACCESS PWR SEAT SYS CNTR MNT EA	Prior authorization is required when the billed charges are greater than $500.		
E1014	RECLIN BACK ADD PED SIZE WHLCHAIR	Prior authorization is required when the billed charges are greater than $500.		
E1015	SHOCK ABSORBER MANUAL WHEELCHAIR EA	Prior authorization is required when the billed charges are greater than $500.		
E1016	SHOCK ABSORBER POWER WHEELCHAIR EA	Prior authorization is required when the billed charges are greater than $500.		
E1017	HEAVY DUTY SHOCK ABSORBR MNL WC EA	Prior authorization is required when the billed charges are greater than $500.		
E1018	HEAVY DUTY SHOCK ABSORBR PWR WC EA	Prior authorization is required when the billed charges are greater than $500.		
E1020	RES LIMB SUP SYS WHEELCHAIR ANY TYP	Prior authorization is required when the billed charges are greater than $500.		
E1028	WC ACCSS MANL SWINGAWAY OTH CNTRL	Prior authorization is required when the billed charges are greater than $500.		
E1029	WHEELCHAIR ACCESS VENT TRAY FIX	Prior authorization is required when the billed charges are greater than $500.		
E1030	WHLCHAIR ACCESS VENT TRAY GIMBALED	Prior authorization is required when the billed charges are greater than $500.		
E1031	ROLLABOUT CHAIR W/CASTRS 5 IN/GT	Prior authorization is required when the billed charges are greater than $500.		
E1035	MX-PSTN PT TRNSF SYS PT </= 300 LBS	Prior authorization is required when the billed charges are greater than $500.		
E1036	MX-PSTN PT TRNSF SYS PT > 300 LBS	Prior authorization is required when the billed charges are greater than $500.		
E1037	TRANSPORT CHAIR PEDIATRIC SIZE	Prior authorization is required when the billed charges are greater than $500.		
E1038	TRNSPRT CHAIR PT WT CAP TO&= 300 LB	Prior authorization is required when the billed charges are greater than $500.		
E1039	TRNSPRT CHAIR ADLT PT WT CAP>300 LB	Prior authorization is required when the billed charges are greater than $500.		
E1050	FULL RECLINE WC FIX ARM DETACH LEGS	Prior authorization is required when the billed charges are greater than $500.		
E1060	FULL RECLN WHLCHAR;DTACH ARM LEGRST	Prior authorization is required when the billed charges are greater than $500.		
E1070	FULL RECLN WHLCHR;DTACH ARM FOOTRST	Prior authorization is required when the billed charges are greater than $500.		
E1083	HEMI-W/C; FIXED ARM DETACH LEGREST	Prior authorization is required when the billed charges are greater than $500.		
E1084	HEMI-WHLCHAIR; DTACHBLE ARMS LEGRST	Prior authorization is required when the billed charges are greater than $500.		
E1085	HEMI-WHLCHAIR;FIX ARM DTACH FOOTRST	Prior authorization is required when the billed charges are greater than $500.		
E1086	HEMI-WHLCHAIR; DTACHBL ARMS FOOTRST	Prior authorization is required when the billed charges are greater than $500.		
E1087	HI-STRGTH WHLCHAIR; FIX ARMS LEGRST	Prior authorization is required when the billed charges are greater than $500.		
E1088	HI-STRGTH WHLCHAIR;DTACH ARM LEGRST	Prior authorization is required when the billed charges are greater than $500.		
E1089	HI-STRGTH WHLCHAIR; FIX ARM FOOTRST	Prior authorization is required when the billed charges are greater than $500.		
E1090	HI-STRGTH WHLCHAR;DTACH ARM FOOTRST	Prior authorization is required when the billed charges are greater than $500.		
E1092	WIDE HEVY-DUT WHLCHR; DTACH ARM LEG	Prior authorization is required when the billed charges are greater than $500.		
E1093	WIDE HEVY-DUT WHLCHR;DTACH ARM FOOT	Prior authorization is required when the billed charges are greater than $500.		
E1100	SEMI-RECLN WHLCHR;FIX ARM DTACH LEG	Prior authorization is required when the billed charges are greater than $500.		
E1110	SEMI-RECLN WHLCHR; DTACH ARM LEGRST	Prior authorization is required when the billed charges are greater than $500.		
E1130	STD WHLCHAIR; FIX ARM DTACH FOOTRST	Prior authorization is required when the billed charges are greater than $500.		
E1140	WHLCHAIR; DTACHBLE ARMS FOOTRESTS	Prior authorization is required when the billed charges are greater than $500.		
E1150	WHLCHAIR; DTACHBLE ARMS LEGRESTS	Prior authorization is required when the billed charges are greater than $500.		
E1160	WHLCHAIR; FIX ARMS DTACHBL LEGRESTS	Prior authorization is required when the billed charges are greater than $500.		
E1161	MANUAL ADLT SZ WC INCL TILT SPACE	Prior authorization is required when the billed charges are greater than $500.		
E1170	AMP WHLCHAIR; FIX ARM DTACH LEGREST	Prior authorization is required when the billed charges are greater than $500.		
E1171	AMP WHLCHAIR;FIX ARM NO FOOT/LEGRST	Prior authorization is required when the billed charges are greater than $500.		
E1172	AMP WHLCHR;DTACH ARM NO FOOT/LEGRST	Prior authorization is required when the billed charges are greater than $500.		
E1180	AMP WHLCHAIR; DTACHBL ARMS FOOTRSTS	Prior authorization is required when the billed charges are greater than $500.		
E1190	AMP WHLCHAIR; DTACHBL ARMS LEGRESTS	Prior authorization is required when the billed charges are greater than $500.		
E1195	HVY DUT WHLCHR;FIX ARM DTACH LEGRST	Prior authorization is required when the billed charges are greater than $500.		
E1200	AMP WHLCHAIR; FIX ARM DTACH FOOTRST	Prior authorization is required when the billed charges are greater than $500.		
E1220	WHEELCHAIR; SPCL SIZED/CONSTRUCTED	Prior authorization is required when the billed charges are greater than $500.		
E1221	WHEELCHAIR WITH FIXED ARM FOOTRESTS	Prior authorization is required when the billed charges are greater than $500.		

E1222	WHEELCHAIR W/FIX ARM ELEV LEGRESTS	Prior authorization is required when the billed charges are greater than $500.		
E1223	WHLCHAIR W/DETACHBLE ARMS FOOTRESTS	Prior authorization is required when the billed charges are greater than $500.		
E1224	WHLCHAIR W/DTACHBL ARMS ELEV LEGRST	Prior authorization is required when the billed charges are greater than $500.		
E1225	WC ACCESS MNL SEMIRECLINING BACK EA	Prior authorization is required when the billed charges are greater than $500.		
E1226	WC ACCESS MNL FULL RECLIN BACK EA	Prior authorization is required when the billed charges are greater than $500.		
E1227	SPECIAL HEIGHT ARMS FOR WHEELCHAIR	Prior authorization is required when the billed charges are greater than $500.		
E1228	SPECIAL BACK HEIGHT FOR WHEELCHAIR	Prior authorization is required when the billed charges are greater than $500.		
E1229	Wheelchair, pediatric size, not otherwise specified	Prior authorization is required for billed charges greater than $500.		
E1230	PWR OP VEH SPEC BRAND&MODEL NUMBER	Prior authorization is required when the billed charges are greater than $500.		
E1231	WC PED SZ TILT-IN-SPACE RIGD W/SEAT	Prior authorization is required when the billed charges are greater than $500.		
E1232	WC PED SZ TILT-IN-SPACE FOLD W/SEAT	Prior authorization is required when the billed charges are greater than $500.		
E1233	WC PED SZ TILT-IN-SPCE RIGD NO SEAT	Prior authorization is required when the billed charges are greater than $500.		
E1234	WC PED SZ TILT-IN-SPCE FOLD NO SEAT	Prior authorization is required when the billed charges are greater than $500.		
E1235	WC PED SZ RIGD ADJUSTBL W/SEAT SYS	Prior authorization is required when the billed charges are greater than $500.		
E1236	WC PED SZ FOLD ADJUSTBL W/SEAT SYS	Prior authorization is required when the billed charges are greater than $500.		
E1237	WC PED SZ RIGD ADJUSTBL NO SEAT SYS	Prior authorization is required when the billed charges are greater than $500.		
E1238	WC PED SZ FOLD ADJUSTBL NO SEAT SYS	Prior authorization is required when the billed charges are greater than $500.		
E1239	Power wheelchair, pediatric size, not otherwise specified	Prior authorization is required for billed charges greater than $500.		
E1240	LGHTWT WHLCHAIR; DTACH ARMS LEGRSTS	Prior authorization is required when the billed charges are greater than $500.		
E1250	LGHTWT WHLCHR;FIX ARM DTACH FOOTRST	Prior authorization is required when the billed charges are greater than $500.		
E1260	LGHTWT WHLCHAIR; DTACH ARMS FOOTRST	Prior authorization is required when the billed charges are greater than $500.		
E1270	LGHTWT WHLCHR; FIX ARM DTACH LEGRST	Prior authorization is required when the billed charges are greater than $500.		
E1280	HEVY-DUTY WHLCHR; DTACH ARMS LEGRST	Prior authorization is required when the billed charges are greater than $500.		
E1285	HEVY-DUTY WHLCHR;FIX ARM DTACH FOOT	Prior authorization is required when the billed charges are greater than $500.		
E1290	HEVY-DUTY WHLCHR; DTACH ARM FOOTRST	Prior authorization is required when the billed charges are greater than $500.		
E1295	HEVY-DUTY WHLCHAIR; FIX ARMS LEGRST	Prior authorization is required when the billed charges are greater than $500.		
E1296	SPECIAL WHEELCHAIR SEAT HT FROM FLR	Prior authorization is required when the billed charges are greater than $500.		
E1297	SPECIAL WHLCHAIR SEAT DEPTH UPHLSTR	Prior authorization is required when the billed charges are greater than $500.		
E1298	SPCL WHLCHAIR SEAT DPTH&/WDTH CNSTR	Prior authorization is required when the billed charges are greater than $500.		
E1300	WHIRLPOOL PORTABLE	Prior authorization is required when the billed charges are greater than $500.		
E1310	WHIRLPOOL NONPORTABLE	Prior authorization is required when the billed charges are greater than $500.		
E1352	OXYGEN ACC FLW REG CPBL POS INSP PR	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1072 Oxygen and HHO-DE-MP-1030 Home Oxygen Therapy	
E1353	REGULATOR	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1072 Oxygen and HHO-DE-MP-1030 Home Oxygen Therapy	
E1354	O2 ACCESS CART PRTBLE CYL/CONC REPL	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1072 Oxygen and HHO-DE-MP-1030 Home Oxygen Therapy	
E1355	STAND/RACK	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1072 Oxygen and HHO-DE-MP-1030 Home Oxygen Therapy	
E1356	O2 ACCESS BTTRY PACK/CRTRDGE REPL	Prior authorization is required when the billed charges are greater than $500.		
E1357	O2 ACCESS BATTRY CHARGER REPL EA	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1072 Oxygen and HHO-DE-MP-1030 Home Oxygen Therapy	
E1358	O2 ACCESS DC POWER ADAPTER REPL EA	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1072 Oxygen and HHO-DE-MP-1030 Home Oxygen Therapy	
E1372	IMMERSION EXTERNAL HEATER NEBULIZER	Prior authorization is required when the billed charges are greater than $500.		
E1390	O2 CONC 85%/>02 CONC PRSC FLW RATE	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1072 Oxygen and HHO-DE-MP-1030 Home Oxygen Therapy	
E1391	02 CONC 2 DEL 85%/>02 CONC FLW RATE	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1072 Oxygen and HHO-DE-MP-1030 Home Oxygen Therapy	
E1392	PORTABLE OXYGEN CONCENTRATOR RENTAL	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1072 Oxygen and HHO-DE-MP-1030 Home Oxygen Therapy	
E1399	Durable medical equipment, miscellaneous	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1134 Portable External Infusion Pump, Home Oxygen Therapy HHO-DE-MP-1030, Pneumatic Compression Devices HHO-DE-MP-1144 and HHO-DE-MP-1072 Oxygen	
E1405	O2&WATR VAPR ENRICH SYS W/HEAT DEL	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1072 Oxygen and HHO-DE-MP-1030 Home Oxygen Therapy	
E1406	O2&WATR VAPR ENRCH SYS NO HEAT DEL	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1072 Oxygen and HHO-DE-MP-1030 Home Oxygen Therapy	
E1500	CENTRIFUGE FOR DIALYSIS	Prior authorization is required when the billed charges are greater than $500.		
E1510	KIDNEY DIALYSAT DEL SYS KIDNEY MACH	Prior authorization is required when the billed charges are greater than $500.		
E1520	HEPARIN INFUSION PUMP HEMODIALYSIS	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1246 Home Dialysis Equipment and Supplies	
E1530	AIR BUBBLE DETECTR HEMODIAL EA REPL	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1246 Home Dialysis Equipment and Supplies	
E1540	PRESSURE ALARM HEMODIAL EA REPL	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1246 Home Dialysis Equipment and Supplies	
E1550	BATH CONDUCTIVITY METER HEMODIAL EA	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1246 Home Dialysis Equipment and Supplies	

E1560	BLD LEAK DETECTOR HEMODIAL EA REPL	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1246 Home Dialysis Equipment and Supplies	
E1570	ADJUSTABLE CHAIR FOR ESRD PATIENTS	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1246 Home Dialysis Equipment and Supplies	
E1575	TRNSDUCR PRTCTR/BARR HEMODIAL SZ-10	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1246 Home Dialysis Equipment and Supplies	
E1580	UNIPUNCTURE CONTROL SYSTEM HEMODIAL	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1246 Home Dialysis Equipment and Supplies	
E1590	HEMODIALYSIS MACHINE	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1246 Home Dialysis Equipment and Supplies	
E1592	AUTO INTERMIT PERITON DIALYSIS SYS	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1246 Home Dialysis Equipment and Supplies	
E1594	CYCLR DIALYSIS MACH PERITON DIALYS	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1246 Home Dialysis Equipment and Supplies	
E1600	DEL &OR INSTL CHARGES HEMODIAL EQP	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1246 Home Dialysis Equipment and Supplies	
E1610	RVRS OSMOSIS H2O PURIF SYS HEMODIAL	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1246 Home Dialysis Equipment and Supplies	
E1615	DEIONIZER H2O PURIF SYS HEMODIAL	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1246 Home Dialysis Equipment and Supplies	
E1620	BLOOD PUMP HEMODIALYSIS REPLACEMENT	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1246 Home Dialysis Equipment and Supplies	
E1625	WATER SOFTENING SYSTEM HEMODIALYSIS	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1246 Home Dialysis Equipment and Supplies	
E1630	RECIPROCAT PERITON DIALYSIS SYSTEM	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1246 Home Dialysis Equipment and Supplies	
E1632	WEARABLE ARTIFICIAL KIDNEY EACH	Prior authorization is required when the billed charges are greater than $500. Reference policies for additional information.	HHO-DE-MP-1246 Home Dialysis Equipment and Supplies	
E1634	PERITONEAL DIALYSIS CLAMPS EACH	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1246 Home Dialysis Equipment and Supplies	
E1635	COMPACT TRAVEL HEMODIALYZER SYSTEM	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1246 Home Dialysis Equipment and Supplies	
E1636	SORBENT CARTRIDGES HEMODIAL PER 10	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1246 Home Dialysis Equipment and Supplies	
E1637	HEMOSTATS EACH	Prior authorization is required when the billed charges are greater than $500.		
E1639	SCALE EACH	Prior authorization is required when the billed charges are greater than $500.		
E1699	DIALYSIS EQUIPMENT NOS	Prior authorization is required for billed charges greater than $500.		
E1700	JAW MOTION REHABILITATION SYSTEM	Prior authorization is required when the billed charges are greater than $500.		
E1701	REPL CUSHNS JAW MOT REHAB SYS PKG 6	Prior authorization is required when the billed charges are greater than $500.		
E1702	REPL MSR SCLS JAW MOT REHAB SYS 200	Prior authorization is required when the billed charges are greater than $500.		
E1800	DYN ADJUSTABLE ELB EXT/FLX DEVC	Prior authorization is required when the billed charges are greater than $500.		
E1801	STATIC PROGRESSV STRETCH ELBOW DEVC	Prior authorization is required when the billed charges are greater than $500.		
E1802	DYN ADJUSTBL FORARM PRON/SUPIN DEVC	Prior authorization is required when the billed charges are greater than $500.		
E1805	DYN ADJUSTABLE WRIST EXT/FLX DEVC	Prior authorization is required when the billed charges are greater than $500.		
E1806	STATIC PROGRESSV STRETCH WRIST DEVC	Prior authorization is required when the billed charges are greater than $500.		
E1810	DYN ADJUSTABLE KNEE EXT/FLX DEVC	Prior authorization is required when the billed charges are greater than $500.		
E1811	STATIC PROGRESSV STRETCH KNEE DEVC	Prior authorization is required when the billed charges are greater than $500.		
E1812	DYN KNEE EXT/FLEX DEVC RESIST CNTRL	Prior authorization is required when the billed charges are greater than $500.		
E1815	DYN ADJ ANK EXT/FLX DVC W/INTF MATL	Prior authorization is required when the billed charges are greater than $500.		
E1816	STATIC PROGRESSV STRETCH ANKLE DEVC	Prior authorization is required when the billed charges are greater than $500.		
E1818	STATIC PROGRSV STRETCH FOREARM DEVC	Prior authorization is required when the billed charges are greater than $500.		
E1820	REPL SFT INTERFCE MATL DYN EXT/FLX	Prior authorization is required when the billed charges are greater than $500.		
E1821	REPL SFT INTERFCE MATL/CUFF BI-DIR	Prior authorization is required when the billed charges are greater than $500.		
E1825	DYN ADJUSTABLE FINGER EXT/FLX DEVC	Prior authorization is required when the billed charges are greater than $500.		
E1830	DYN ADJUSTABLE TOE EXT/FLX DEVC	Prior authorization is required when the billed charges are greater than $500.		
E1831	STATIC PROGRESSIVE STRETCH TOE DEVC	Prior authorization is required when the billed charges are greater than $500.		
E1840	DYN ADJUST SHLDR FLX/ABDUCT/ROT DVC	Prior authorization is required when the billed charges are greater than $500.		
E1841	STATIC PROGRS STRETCH SHOULDER DEVC	Prior authorization is required when the billed charges are greater than $500.		
E1902	CMNCT BD NON-ELEC AUG/ALTERNTV DEVC	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1077 Speech Generating Devices	
E2000	GASTR SUCTN PUMP HOME MODEL ELEC	Prior authorization is required when the billed charges are greater than $500.		
E2100	BLD GLU MON INTEGRT VOICE SYNTHESZR	Prior authorization is required when the billed charges are greater than $500.		
E2101	BLD GLU MON INTGRT LANCING/BLD SAMP	Prior authorization is required when the billed charges are greater than $500.		
E2102	ADJUNCTIVE CONT GLUCOSE MON/RCVR	Prior authorization is required when the billed charges are greater than $500.		
E2103	Non-adjunctive, non-implanted continuous glucose monitor or receiver	Prior authorization is required when the billed charges are greater than $500.		
E2120	PULSE GEN SYS TYMPANIC TX INNR EAR	Prior authorization is required when the billed charges are greater than $500.		
E2201	MNL WC ACSS SEAT WDTH >/=20 IN &<24	Prior authorization is required when the billed charges are greater than $500.		
E2202	MNL WC ACSS SEAT WIDTH 24-27 IN	Prior authorization is required when the billed charges are greater than $500.		

E2203	MNL WC ACSS SEAT DEPTH 20 < 11 IN	Prior authorization is required when the billed charges are greater than $500.		
E2204	MNL WC ACSS SEAT DEPTH 22-25 IN	Prior authorization is required when the billed charges are greater than $500.		
E2205	MNL WC HANDRIM W/O PROJ REPL EACH	Prior authorization is required when the billed charges are greater than $500.		
E2206	MANL WC AC WL ASM CMPL REPL ONLY EA	Prior authorization is required when the billed charges are greater than $500.		
E2207	WHLCHAIR ACCESS CRUTCH&CANE HLDR EA	Prior authorization is required when the billed charges are greater than $500.		
E2208	WHEELCHAIR ACCESS CYL TANK CARR EA	Prior authorization is required when the billed charges are greater than $500.		
E2209	ARM TROUGH W/WO HAND SUPPORT EACH	Prior authorization is required when the billed charges are greater than $500.		
E2210	WC ACESS BEARINGS ANY TYPE REPL EA	Prior authorization is required when the billed charges are greater than $500.		
E2211	MNL WC ACESS PNEUMAT PROPULSN TIRE	Prior authorization is required when the billed charges are greater than $500.		
E2212	MNL WC TUBE PNEUMAT PROPULSION TIRE	Prior authorization is required when the billed charges are greater than $500.		
E2213	MNL WC INSRT PNEUMAT PROPULSN TIRE	Prior authorization is required when the billed charges are greater than $500.		
E2214	MNL WC ACCESS PNEUMAT CASTER TIRE	Prior authorization is required when the billed charges are greater than $500.		
E2215	MNL WC ACSS TUBE PNEUMAT CASTR TIRE	Prior authorization is required when the billed charges are greater than $500.		
E2216	MNL WC ACSS FOAM FILL PROPULSN TIRE	Prior authorization is required when the billed charges are greater than $500.		
E2217	MNL WC ACCSS FOAM FILL CASTER TIRE	Prior authorization is required when the billed charges are greater than $500.		
E2218	MNL WC ACCSS FOAM PROPULSION TIRE	Prior authorization is required when the billed charges are greater than $500.		
E2219	MNL WC ACSS FOAM CASTER TIRE ANY SZ	Prior authorization is required when the billed charges are greater than $500.		
E2220	MNL WC AC SLD PROP T SZ RPL ONLY EA	Prior authorization is required when the billed charges are greater than $500.		
E2221	MNL WC AC SLD C TIR SZ REPL ONLY EA	Prior authorization is required when the billed charges are greater than $500.		
E2222	MNL WC AC SLD C TIRE I WHL SZ RPL E	Prior authorization is required when the billed charges are greater than $500.		
E2224	MNL WC AC P WHL EXCL T SZ RPL ONL E	Prior authorization is required when the billed charges are greater than $500.		
E2225	MNL WC CASTR WHL EXCLD TIRE REPL	Prior authorization is required when the billed charges are greater than $500.		
E2226	MNL WC ACSS CASTR FORK REPL ONLY	Prior authorization is required when the billed charges are greater than $500.		
E2227	MNL WC GEAR RED DRIVE WHEEL EACH	Prior authorization is required when the billed charges are greater than $500.		
E2228	MNL WC WHL BRAKE SYS&LOCK COMPL EA	Prior authorization is required when the billed charges are greater than $500.		
E2230	MNL WHEELCHAIR ACCESS MNL STAND SYS	Prior authorization is required when the billed charges are greater than $500.		
E2231	MNL WC ACCESS SOLID SEAT SUPP BASE	Prior authorization is required when the billed charges are greater than $500.		
E2291	BACK PLANR PED WC FIX ATTCH HARDWRE	Prior authorization is required when the billed charges are greater than $500.		
E2292	SEAT PLANR PED WC FIX ATTCH HARDWRE	Prior authorization is required when the billed charges are greater than $500.		
E2293	BACK CONTRD PED WC ATTCH HARDWARE	Prior authorization is required when the billed charges are greater than $500.		
E2294	SEAT CONTRD PED WC ATTCH HARDWARE	Prior authorization is required when the billed charges are greater than $500.		
E2295	MNL WC ACCESS PED SIZE WC SEAT FRME	Prior authorization is required when the billed charges are greater than $500.		
E2300	WC ACC PWR SEAT ELEV SYS ANY TYPE	Prior authorization is required when the billed charges are greater than $500.		
E2301	WHEELCHAIR ACC PWR STND SYS ANY TYP	Prior authorization is required when the billed charges are greater than $500.		
E2310	PWR WC ACSS ELEC CNCT BETWN WC CNTR	Prior authorization is required when the billed charges are greater than $500.		
E2311	PWR WC ACSS ELEC CNCT BETWN WC CNTR	Prior authorization is required when the billed charges are greater than $500.		
E2312	POWER WC HAND/CHIN CONTRL INTERFACE	Prior authorization is required when the billed charges are greater than $500.		
E2313	POWER AC HARNESS UPGRD EXP CONTRLLR	Prior authorization is required when the billed charges are greater than $500.		
E2321	PWR WC ACSS HND CNTRL NO PRPRTNL	Prior authorization is required when the billed charges are greater than $500.		
E2322	PWR WC ACSS MX MECH SWTCH NOPRPRTNL	Prior authorization is required when the billed charges are greater than $500.		
E2323	PWR WC ACSS SPCLTY JOYSTCK HND PRFB	Prior authorization is required when the billed charges are greater than $500.		
E2324	PWR WC ACSS CHIN CUP CHIN CNTRL INT	Prior authorization is required when the billed charges are greater than $500.		
E2325	PWR WC ACSS SIP&PUFF NONPRPRTNAL	Prior authorization is required when the billed charges are greater than $500.		
E2326	PWR WC ACSS BREATH TUBE KIT SIP&PUF	Prior authorization is required when the billed charges are greater than $500.		
E2327	PWR WC ACSS HEAD CNTRL MECH PRPRTNL	Prior authorization is required when the billed charges are greater than $500.		
E2328	PWR WC ACSS HEAD/EXT ELEC PRPRTNL	Prior authorization is required when the billed charges are greater than $500.		
E2329	PWR WC ACSS CNTC SWTCH NOPRPRTNL	Prior authorization is required when the billed charges are greater than $500.		
E2330	PWR WC ACCSS PROX SWTCH NOPROPRTNL	Prior authorization is required when the billed charges are greater than $500.		
E2331	PWR WC ACSS ATDANT CNTRL PROPRTNAL	Prior authorization is required when the billed charges are greater than $500.		
E2340	POWER WC NONSTAND SEAT WD 20-23 IN	Prior authorization is required when the billed charges are greater than $500.		
E2341	PWR WC ACSS NONSTD SEAT W 24-27 IN	Prior authorization is required when the billed charges are greater than $500.		
E2342	PWR WC NONSTD SEAT DEPTH 20/21 IN	Prior authorization is required when the billed charges are greater than $500.		
E2343	PWR WC NONSTD SEAT DEPTH 22-25 IN	Prior authorization is required when the billed charges are greater than $500.		
E2351	PWR WC ACSS ELEC OP SPCH GEN DEVC	Prior authorization is required when the billed charges are greater than $500.		
E2358	PWR WC GRP 34 NONSEALED LA BATT EA	Prior authorization is required when the billed charges are greater than $500.		
E2359	PWR WC GRP 34 SEALED LA BATT EA	Prior authorization is required when the billed charges are greater than $500.		
E2360	PWR WC ACSS 22 NF NON-SEALED BATTRY	Prior authorization is required when the billed charges are greater than $500.		
E2361	PWR WC ACSS 22NF SEALED LEAD BATTRY	Prior authorization is required when the billed charges are greater than $500.		
E2362	PWR WC ACSS GRP 24 NON-SEALED BATT	Prior authorization is required when the billed charges are greater than $500.		
E2363	PWR WC ACSS GRP 24 SEALED BATTRY	Prior authorization is required when the billed charges are greater than $500.		
E2364	PWR WC ACSS U-1 NON-SEALED BATTRY	Prior authorization is required when the billed charges are greater than $500.		
E2365	PWR WC ACSS U-1 SEALED BATTRY	Prior authorization is required when the billed charges are greater than $500.		
E2366	PWR WC ACSS BATTRY CHARGER 1 MODE	Prior authorization is required when the billed charges are greater than $500.		
E2367	PWR WC ACSS BATTRY CHARGER DUL MODE	Prior authorization is required when the billed charges are greater than $500.		
E2368	PWR WC CMPNT DR WHEEL MTR REPL ONLY	Prior authorization is required when the billed charges are greater than $500.		
E2369	PWR WC CMPNNT DR WHL GR BX RPL ONLY	Prior authorization is required when the billed charges are greater than $500.		
E2370	P WC CMP INT DR WHL MTR&GB CMB RPL	Prior authorization is required when the billed charges are greater than $500.		
E2371	PWR WC GRP 27 SEALED LEAD ACID BATT	Prior authorization is required when the billed charges are greater than $500.		

E2372	PWR WC GRP 27 NONSEAL LED ACID BATT	Prior authorization is required when the billed charges are greater than $500.		
E2373	PWR WC MINI COMPACT REMOTE JOYSTICK	Prior authorization is required when the billed charges are greater than $500.		
E2374	PWR WC STANDRD REMOTE JOYSTICK REPL	Prior authorization is required when the billed charges are greater than $500.		
E2375	PWR WC NONEXPANDBLE CONTROLLER REPL	Prior authorization is required when the billed charges are greater than $500.		
E2376	PWR WC EXPANDABLE CONTROLLER REPL	Prior authorization is required when the billed charges are greater than $500.		
E2377	PWR WC EXPANDBL CONTROLLER UPGRADE	Prior authorization is required when the billed charges are greater than $500.		
E2378	POWER WC CMPNT ACTUATOR REPL ONLY	Prior authorization is required when the billed charges are greater than $500.		
E2381	PWR WC PNEUMATIC WHEEL TIRE REPL EA	Prior authorization is required when the billed charges are greater than $500.		
E2382	PWR WC TUBE WHEEL TIRE REPL EA	Prior authorization is required when the billed charges are greater than $500.		
E2383	PWR WC INSERT WHEEL TIRE REPL EA	Prior authorization is required when the billed charges are greater than $500.		
E2384	PWR WC PNEUMATIC CASTR TIRE REPL EA	Prior authorization is required when the billed charges are greater than $500.		
E2385	PWR WC TUBE CASTER TIRE REPL EA	Prior authorization is required when the billed charges are greater than $500.		
E2386	PWR WC FOAM FILL WHEEL TIRE REPL EA	Prior authorization is required when the billed charges are greater than $500.		
E2387	PWR WC FOAM FILL CASTR TIRE REPL EA	Prior authorization is required when the billed charges are greater than $500.		
E2388	PWR WC FOAM WHEEL TIRE REPL ONLY EA	Prior authorization is required when the billed charges are greater than $500.		
E2389	PWR WC FORM CASTER TIRE REPL EACH	Prior authorization is required when the billed charges are greater than $500.		
E2390	PWR WC SOLID WHEEL TIRE REPL EACH	Prior authorization is required when the billed charges are greater than $500.		
E2391	PWR WC SOLID CASTER TIRE REPL EACH	Prior authorization is required when the billed charges are greater than $500.		
E2392	PWR WC S CASTR TIRE INTEGRT REPL EA	Prior authorization is required when the billed charges are greater than $500.		
E2394	PWR WC DRIVE WHEEL EXCL TIRE REPL	Prior authorization is required when the billed charges are greater than $500.		
E2395	PWR WC CASTER WHEEL EXCL TIRE REPL	Prior authorization is required when the billed charges are greater than $500.		
E2396	PWR WC CASTER FORK REPL ONLY EACH	Prior authorization is required when the billed charges are greater than $500.		
E2397	POWER WC LITHIUM BASED BATTERY EACH	Prior authorization is required when the billed charges are greater than $500.		
E2398	WHEELCHAIR AC DYN POS HARDWARE BACK	Prior authorization is required when the billed charges are greater than $500.		
E2402	Negative pressure wound therapy electrical pump, stationary or portable	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1039 Negative Pressure Wound Therapy	
E2500	SPEECH GEN DEV DIGTIZD</=8 MINS REC	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1077 Speech Generating Devices	
E2502	SPCH GEN DEVC DGTZD>8<= 20 MINS REC	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1077 Speech Generating Devices	
E2504	SPCH GEN DEVC DGTZD>20</=40 MIN REC	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1077 Speech Generating Devices	
E2506	SPCH GEN DEVC DIGTIZD>40 MINS REC	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1077 Speech Generating Devices	
E2508	SPCH GEN DEVC SYNTHSIZD REQ MESS	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1077 Speech Generating Devices	
E2510	SPCH GEN DVC SYNTHSIZD MX METH MESS	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1077 Speech Generating Devices	
E2511	SPEECH GENERATING SOFTWARE PROGRAM	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1077 Speech Generating Devices	
E2512	ACSS SPCH GEN DEVICE MOUNTING SYS	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1077 Speech Generating Devices	
E2599	ACCESS SPEECH GENERATING DEVICE NOC	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1077 Speech Generating Devices	
E2601	GEN WC SEAT CUSHN WIDTH < 22 DEPTH	Prior authorization is required when the billed charges are greater than $500.		
E2602	GEN WC SEAT CSHN WDTH 22 IN/GT DPTH	Prior authorization is required when the billed charges are greater than $500.		
E2603	SKN PROTCT WC SEAT WDTH<22IN DPTH	Prior authorization is required when the billed charges are greater than $500.		
E2604	SKN PROTECT WC SEAT WDTH 22 IN/GT	Prior authorization is required when the billed charges are greater than $500.		
E2605	PSTN WC SEAT CUSHN WIDTH < 22 DEPTH	Prior authorization is required when the billed charges are greater than $500.		
E2606	PSTN WC SEAT CSHN WDTH 22IN/GT DPTH	Prior authorization is required when the billed charges are greater than $500.		
E2607	SKN PROTCT&PSTN WC SEAT WDTH <22IN	Prior authorization is required when the billed charges are greater than $500.		
E2608	SKN PROTCT&PSTN WC SEAT WDTH 22IN/>	Prior authorization is required when the billed charges are greater than $500.		
E2609	CUSTOM FAB WHLCHAIR SEAT CUSHN SIZE	Prior authorization is required when the billed charges are greater than $500.		
E2610	WHEELCHAIR SEAT CUSHION POWERED	Prior authorization is required when the billed charges are greater than $500.		
E2611	GEN WC BACK CUSHN WIDTH < 22 IN HT	Prior authorization is required when the billed charges are greater than $500.		
E2612	GEN WC BACK CUSHN WIDTH 22 IN/GT HT	Prior authorization is required when the billed charges are greater than $500.		
E2613	PSTN WC BACK CUSHN POST WDTH <22 IN	Prior authorization is required when the billed charges are greater than $500.		
E2614	PSTN WC BACK CUSHN POST WD 22 IN/>	Prior authorization is required when the billed charges are greater than $500.		
E2615	PSTN WC BACK CUSHN POSTLAT WD<22 IN	Prior authorization is required when the billed charges are greater than $500.		
E2616	PSTN WC BACK CUSH POSTLAT WD 22IN/>	Prior authorization is required when the billed charges are greater than $500.		
E2617	CSTM FAB WC BACK CUSHION ANY SIZE	Prior authorization is required when the billed charges are greater than $500.		
E2619	REPL COVER WC SEAT/BACK CUSHN EA	Prior authorization is required when the billed charges are greater than $500.		
E2620	PSTN WC BACK CUSHN PLANAR WD <22 IN	Prior authorization is required when the billed charges are greater than $500.		
E2621	PSTN WC BACK CUSHN PLANAR WD 22IN/>	Prior authorization is required when the billed charges are greater than $500.		
E2622	SKIN PROTECT WC CUSH WIDTH <22 IN	Prior authorization is required when the billed charges are greater than $500.		
E2623	SKIN PROTECT WC CUSH WIDTH 22 IN/>	Prior authorization is required when the billed charges are greater than $500.		
E2624	SKIN PROTCT&POSITION WC CUSH WD <22	Prior authorization is required when the billed charges are greater than $500.		
E2625	SKIN PROTCT&POSITION WC CUSH W 22/>	Prior authorization is required when the billed charges are greater than $500.		
E2626	WC SHLDR ELB MOBL ARM SUPP ADJUSTBL	Prior authorization is required when the billed charges are greater than $500.		

E2627	WC SHLDR ELB M SUPP ADJUSTBL RANCHO	Prior authorization is required when the billed charges are greater than $500.		
E2628	WC SHLDR ELB MOBIL SUPP RECLINING	Prior authorization is required when the billed charges are greater than $500.		
E2629	WC SHLDR ELB M SUPP FRICTN ARM SUPP	Prior authorization is required when the billed charges are greater than $500.		
E2630	WC SHLDR ELB M SUP MONOSUSP ARM HND	Prior authorization is required when the billed charges are greater than $500.		
E2631	WC ADD MOBIL ARM SUPP ELEV PROX ARM	Prior authorization is required when the billed charges are greater than $500.		
E2632	WC ADD MOBL SUP OFFSET/LAT RCKR ARM	Prior authorization is required when the billed charges are greater than $500.		
E2633	WC ACSS ADD MOBIL ARM SUPP SUPINATR	Prior authorization is required when the billed charges are greater than $500.		
E8000	GAIT TRAINER PED SZ POST SUPP	Prior authorization is required when the billed charges are greater than $500.		
E8001	GAIT TRAINER PED SZ UPRIGHT SUPP	Prior authorization is required when the billed charges are greater than $500.		
E8002	GAIT TRAINER PED SZ ANT SUPP	Prior authorization is required when the billed charges are greater than $500.		
G0017	Psychotherapy for crisis furnished in an applicable site of service (any place of service at which the non-facility rate for psychotherapy for crisis services applies, other than the office setting); first 60 minutes			
G0104	Colorectal cancer screening; flexible sigmoidoscopy	Prior authorization is required for members under the age of 45. Reference policies for additional information.	HHO-DE-MP-1007 Colorectal Cancer Screening	
G0105	Colorectal cancer screening; colonoscopy on individual at high risk	Prior authorization is required for members under the age of 45. Reference policies for additional information.	HHO-DE-MP-1007 Colorectal Cancer Screening	
G0106	Colorectal cancer screening; alternative to G0104, screening sigmoidoscopy, barium enema	Prior authorization is required for members under the age of 45. Reference policies for additional information.	HHO-DE-MP-1007 Colorectal Cancer Screening	
G0120	Colorectal cancer screening; alternative to G0105, screening colonoscopy, barium enema	Prior authorization is required for members under the age of 45. Reference policies for additional information.	HHO-DE-MP-1007 Colorectal Cancer Screening	
G0121	olorectal cancer screening; colonoscopy on individual not meeting criteria for high risk	Prior authorization is required for members under the age of 45. Reference policies for additional information.	HHO-DE-MP-1007 Colorectal Cancer Screening	
G0239	Therapeutic procedures to improve respiratory function or increase strength or endurance of respiratory muscles, two or more individuals (includes monitoring)	Prior authorization is required. Reference policies for additional information.	HHO-DE-RP-1013 Therapy Services	
G0260	Injection procedure for sacroiliac joint; provision of anesthetic, steroid and/or other therapeutic agent, with or without arthrography	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
G0270	Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face-to-face with the patient, each 15 minutes	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1133 Medical Nutrition Management Services	
G0271	Medical nutrition therapy, reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), group (two or more individuals), each 30 minutes	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1133 Medical Nutrition Management Services	
G0281	Electrical Stimulation, (unattended), To One Or More Areas, For Chronic Stage Iii And Stage Iv Pressure Ulcers, Arterial Ulcers, Diabetic Ulcers and Venous Stasis Ulcers Not Demonstrating Measurable Signs Of Healing After 30 Days Of Conventional Care, As Part Of A Therapy Plan To Care	Prior authorization is required. Reference policies for additional information.	HHO-DE-RP-1013 Therapy Services	
G0328	Colorectal cancer screening; fecal occult blood test, immunoassay, one to three simultaneous determinations	Prior authorization is required for members under the age of 45. Reference policies for additional information.	HHO-DE-MP-1007 Colorectal Cancer Screening	
G0341	Percutaneous islet cell transplant, includes portal vein catheterization and infusion	Prior authorization is required.		
G0452	Molecular pathology procedure; physician interpretation and report	Prior authorization is required.		
G0460	Autologous platelet rich plasma for nondiabetic chronic wounds/ulcers, including phlebotomy, centrifugation and all other preparatory procedures, administration and dressings, per treatment	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1132 Skin Replacement Therapy For Chronic Non healing Wounds in The Outpatient Setting	
G6001	Ultrasonic guidance for placement of radiation therapy fields	Prior authorization is required for conditions other than cancer.		
G6002	Stereoscopic x-ray guidance for localization of target volume for the delivery of radiation therapy	Prior authorization is required for conditions other than cancer.		
G6003	Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks: up to 5 mev	Prior authorization is required for conditions other than cancer.		
G6004	Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks: 6-10 mev	Prior authorization is required for conditions other than cancer.		
G6005	Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks: 11-19 mev	Prior authorization is required for conditions other than cancer.		
G6006	Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks: 20 mev or greater	Prior authorization is required for conditions other than cancer.		
G6007	Radiation treatment delivery, two separate treatment areas, three or more ports on a single treatment area, use of multiple blocks: up to 5 mev	Prior authorization is required for conditions other than cancer.		
G6008	Radiation treatment delivery, two separate treatment areas, three or more ports on a single treatment area, use of multiple blocks: 6-10 mev	Prior authorization is required for conditions other than cancer.		
G6009	Radiation treatment delivery, two separate treatment areas, three or more ports on a single treatment area, use of multiple blocks: 11-19 mev	Prior authorization is required for conditions other than cancer.		
G6010	Radiation treatment delivery, two separate treatment areas, three or more ports on a single treatment area, use of multiple blocks: 20 mev or greater	Prior authorization is required for conditions other than cancer.		
G6011	Radiation treatment delivery, three or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; up to 5 mev	Prior authorization is required for conditions other than cancer.		
G6012	Radiation treatment delivery, three or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 6-10 mev	Prior authorization is required for conditions other than cancer.		
G6013	Radiation treatment delivery, three or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 11-19 mev	Prior authorization is required for conditions other than cancer.		

G6014	Radiation treatment delivery, three or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 20 mev or greater	Prior authorization is required for conditions other than cancer.		
G6015	Intensity modulated treatment delivery, single or multiple fields/arcs, via narrow spatially and temporally modulated beams, binary, dynamic MLC, per treatment session	Prior authorization is required.		
G6016	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	Prior authorization is required for conditions other than cancer.		
G6017	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	Prior authorization is required for conditions other than cancer.		
H0015	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	A prior authorization is required. Members must have a behavorial health diagnosis.		
H0035	Mental health partial hospitalization, treatment, less than 24 hours	A prior authorization is required. Members must have a behavorial health diagnosis.		
H0046	Mental health services, not otherwise specified	Prior authorization is required.		
H0047	Alcohol and/or other drug abuse services, not otherwise specified	Prior authorization is required.		
H2034	Alcohol and/or drug abuse halfway house services, per diem	A prior authorization is required. Members must be 18 and older, with a behavioral health diagnosis.		
H2036	Alcohol and/or other drug treatment program, per diem	A prior authorization is required. Members must be 18 and older, with a behavioral health diagnosis.		
J0129	Injection, abatacept, 10 mg (code may be used for medicare when drug administered under the direct supervision of a physician, not for use when drug is self administered	Prior authorization is required.		
J0135	Injection, adalimumab, 20 mg	Prior authorization is required.		
J0172	Injection, aducanumab-avwa, 2 mg	Prior authorization is required.		
J0178	Injection, aflibercept, 1 mg	Prior authorization is required.		
J0180	Injection, agalsidase beta, 1 mg	Prior authorization is required.		
J0221	Injection, alglucosidase alfa, (lumizyme), 10 mg	Prior authorization is required.		
J0222	Injection, patisiran, 0.1 mg	Prior authorization is required.		
J0256	Injection, alpha 1 proteinase inhibitor (human), not otherwise specified, 10 mg	Prior authorization is required.		
J0257	Injection, alpha 1 proteinase inhibitor (human), (glassia), 10 mg	Prior authorization is required.		
J0490	Injection, belimumab, 10 mg	Prior authorization is required.		
J0517	Injection, benralizumab, 1 mg	Prior authorization is required.		
J0567	Injection, cerliponase alfa, 1 mg	Prior authorization is required.		
J0584	Injection, burosumab-twza, 1 mg	Prior authorization is required.		
J0585	Injection, onabotulinumtoxinA, 1 unit	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service. Reference policies for additional information.	HHO-DE-MP-1137 Hyperhidrosis	
J0586	Injection, abobotulinumtoxinA, 5 units	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service.		
J0587	Injection, rimabotulinumtoxinB, 100 units	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service. Reference policies for additional information.	HHO-DE-MP-1137 Hyperhidrosis	
J0588	Injection, incobotulinumtoxinA, 1 unit	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service.		
J0593	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)	Prior authorization is required.		
J0596	Injection, c1 esterase inhibitor (recombinant), ruconest, 10 units	Prior authorization is required.		
J0597	Injection, c-1 esterase inhibitor (human), berinert, 10 units	Prior authorization is required.		
J0598	Injection, c-1 esterase inhibitor (human), cinryze, 10 units	Prior authorization is required.		
J0702	Injection, betamethasone acetate 3 mg and betamethasone sodium phosphate 3 mg	Prior authorization is required.		
J0717	Injection, certolizumab pegol, 1 mg (code may be used for medicare when drug administered under the direct supervision of a physician, not for use when drug is self administered)	Prior authorization is required.		
J0775	Injection, collagenase, clostridium histolyticum, 0.01 mg	Prior authorization is required.		
J0791	Injection, crizanlizumab-tmca, 5 mg	Prior authorization is required.		
J0881	Injection, darbepoetin alfa, 1 microgram (**non-esrd use**)	Prior authorization is required.		
J0882	Injection, darbepoetin alfa, 1 microgram **(for esrd on dialysis**)	Prior authorization is required.		
J0885	Injection, epoetin alfa, (for non-esrd use), 1000 units	Prior authorization is required.		
J0887	Injection, epoetin beta, 1 microgram, (**for esrd on dialysis**)	Prior authorization is required.		
J0888	Injection, epoetin beta, 1 microgram, (**for non esrd use**)	Prior authorization is required.		

J0896	Injection, luspatercept-aamt, 0.25 mg	Prior authorization is required.		
J0897	Injection, denosumab, 1 mg	Prior authorization is required.		
J1071	Injection, testosterone cypionate, 1 mg	Prior authorization is required.		
J1300	Injection, eculizumab, 10 mg	Prior authorization is required.		
J1301	Injection, edaravone, 1 mg	Prior authorization is required.		
J1303	Injection, ravulizumab-cwvz, 10 mg	Prior authorization is required.		
J1305	Injection, evinacumab-dgnb, 5 mg	Prior authorization is required.		
J1322	Injection, elosulfase alfa, 1 mg	Prior authorization is required.		
J1325	Injection, epoprostenol, 0.5 mg	Prior authorization is required.		
J1411	Injection, etranacogene dezaparvovec-drlb, per therapeutic dose	Prior authorization is required.		
J1426	Injection, casimersen, 10 mg	Prior authorization is required.		
J1428	Injection, eteplirsen, 10 mg	Prior authorization is required.		
J1429	Injection, golodirsen, 10 mg	Prior authorization is required.		
J1439	Injection, ferric carboxymaltose, 1 mg	Prior authorization is required.		
J1442	Injection, filgrastim (g-csf), excludes biosimilars, 1 microgram	Prior authorization is required.		
J1454	Injection, fosnetupitant 235 mg and palonosetron 0.25 mg	Prior authorization is required.		
J1458	Injection, galsulfase, 1 mg	Prior authorization is required.		
J1459	Injection, immune globulin (privigen), intravenous, non-lyophilized (e.g., liquid), 500 mg	Prior authorization is required.		
J1554	Injection, immune globulin, intravenous, non-lyophilized (e.g., liquid), not otherwise specified, 500 mg	Prior authorization is required.		
J1556	Injection, immune globulin (bivigam), 500 mg	Prior authorization is required.		
J1557	Injection, immune globulin, (gammaplex), intravenous, non-lyophilized (e.g., liquid), 500 mg	Prior authorization is required.		
J1559	Injection, immune globulin (hizentra), 100 mg	Prior authorization is required.		
J1561	Injection, immune globulin, (gamunex-c/gammaked), non-lyophilized (e.g., liquid), 500 mg	Prior authorization is required.		
J1566	Injection, immune globulin, (gammagard liquid), non-lyophilized, (e.g., liquid), 500 mg	Prior authorization is required.		
J1568	Injection, immune globulin, (octagam), intravenous, non-lyophilized (e.g., liquid), 500 mg	Prior authorization is required.		
J1569	Injection, immune globulin, (gammagard liquid), non-lyophilized, (e.g., liquid), 500 mg	Prior authorization is required.		
J1572	Injection, immune globulin, (flebogamma/flebogamma dif), intravenous, non-lyophilized (e.g., liquid), 500 mg	Prior authorization is required.		
J1574	Injection, ganciclovir sodium (exela) not therapeutically equivalent to j1570, 500 mg	Prior authorization is required.		
J1575	Injection, immune globulin/hyaluronidase, (hyqvia), 100 mg immune globulin	Prior authorization is required.		
J1599	Injection, immune globulin, intravenous, non-lyophilized (e.g., liquid), not otherwise specified, 500 mg	Prior authorization is required.		
J1602	Injection, golimumab, 1 mg, for intravenous use	Prior authorization is required.		
J1632	Injection, brexanolone, 1 mg	Prior authorization is required.		
J1652	Injection, fondaparinux sodium, 0.5 mg	Prior authorization is required.		
J1726	Injection, hydroxyprogesterone caproate, (makena), 10 mg	Prior authorization is required.		
J1743	Injection, idursulfase, 1 mg	Prior authorization is required.		
J1745	Injection, infliximab, excludes biosimilar, 10 mg	Prior authorization is required.		
J1786	Injection, imiglucerase, 10 units	Prior authorization is required.		
J1812	Insulin (fiasp), per 5 units	Prior authorization is required.		
J1814	Insulin (lyumjev), per 5 units	Prior authorization is required.		
J1823	Injection, inebilizumab-cdon, 1 mg	Prior authorization is required.		
J1931	Injection, laronidase, 0.1 mg	Prior authorization is required.		
J1941	Injection, furosemide (furoscix), 20 mg	Prior authorization is required.		
J1950	Injection, leuprolide acetate (for depot suspension), per 3.75 mg	Prior authorization is required.		
J2182	Injection, mepolizumab, 1 mg	Prior authorization is required.		
J2212	Injection, methylnaltrexone, 0.1 mg	Prior authorization is required.		
J2323	Injection, natalizumab, 1 mg	Prior authorization is required.		
J2326	Injection, nusinersen, 0.1 mg	Prior authorization is required.		
J2350	Injection, ocrelizumab, 1 mg	Prior authorization is required.		
J2357	Injection, omalizumab, 5 mg	Prior authorization is required.		
J2402	Injection, chloroprocaine hydrochloride (clorotekal), per 1 mg	Prior authorization is required.		
J2503	Injection, pegaptanib sodium, 0.3 mg	Prior authorization is required.		
J2506	Injection, pegfilgrastim, excludes biosimilar, 0.5 mg	Prior authorization is required.		
J2507	Injection, pegloticase, 1 mg	Prior authorization is required.		
J2561	Injection, phenobarbital sodium (sezaby), 1 mg	Prior authorization is required.		
J2778	Injection, ranibizumab, 0.1 mg	Prior authorization is required.		
J2786	Injection, reslizumab, 1 mg	Prior authorization is required.		
J2796	Injection, romiplostim, 10 micrograms	Prior authorization is required.		
J2840	Injection, sebelipase alfa, 1 mg	Prior authorization is required.		

J2998	Plasminogen, human-tvmh (Ryplazim)	Prior authorization is required.		
J3032	Injection, eptinezumab-jjmr, 1 mg	Prior authorization is required.		
J3060	Injection, taliglucerase alfa, 10 units	Prior authorization is required.		
J3241	Injection, teprotumumab-trbw, 10 mg	Prior authorization is required.		
J3262	Injection, tocilizumab, 1 mg	Prior authorization is required.		
J3285	Injection, treprostinil, 1 mg	Prior authorization is required.		
J3357	Ustekinumab, for **subcutaneous** injection, 1 mg	Prior authorization is required.		
J3358	Ustekinumab, for **intravenous** injection, 1 mg	Prior authorization is required.		
J3380	Injection, vedolizumab, 1 mg	Prior authorization is required.		
J3385	Injection, velaglucerase alfa, 100 units	Prior authorization is required.		
J3396	Injection, verteporfin, 0.1 mg	Prior authorization is required.		
J3397	Injection, vestronidase alfa-vjbk, 1 mg	Prior authorization is required.		
J3398	Injection, voretigene neparvovec-rzyl, 1 billion vector genomes	Prior authorization is required.		
J3489	Injection, zoledronic acid, 1 mg	Prior authorization is required.		
J3490	Unclassified drugs	The following drugs require prior authorization: Tegsedi, Nulibry, Uptravi		
J3590	Unclassified biologics	The following drugs require prior authorization: Hemgenix, Skysona, Zynteglo		
J7170	Injection, emicizumab-kxwh, 0.5 mg	Prior authorization is required.		
J7179	Injection, von willebrand factor (recombinant), (vonvendi), 1 i.u. vwf:rco	Prior authorization is required.		
J7183	Injection, von willebrand factor complex (human), wilate, 1 i.u. vwf:rco	Prior authorization is required.		
J7185	Injection, factor viii (antihemophilic factor, recombinant) (xyntha), per i.u.	Prior authorization is required.		
J7186	Injection, antihemophilic factor viii/von willebrand factor complex (human), per factor viii i.u.	Prior authorization is required.		
J7187	Injection, von willebrand factor complex (humate-p), per iu vwf:rco	Prior authorization is required.		
J7189	Factor viia (antihemophilic factor, recombinant), per 1 microgram	Prior authorization is required.	HHO-DE-MP-1088 Electroencephalogram (EEG) Technologies	
J7192	Factor viii (antihemophilic factor, recombinant) per i.u., not otherwise specified	Prior authorization is required.		
J7205	Injection, factor viii fc fusion protein (recombinant), per iu	Prior authorization is required.		
J7320	Hyaluronan or derivitive, genvisc 850, for intra-articular injection, 1 mg	Prior authorization is required.		
J7321	Hyaluronan or derivative, hyalgan or supartz, for intra-articular injection, per dose	Prior authorization is required.		
J7323	Hyaluronan or derivative, euflexxa, for intra-articular injection, per dose	Prior authorization is required.		
J7324	Hyaluronan or derivative, orthovisc, for intra-articular injection, per dose	Prior authorization is required.		
J7325	Hyaluronan or derivative, synvisc or synvisc- one, for intra-articular injection, 1 mg	Prior authorization is required.		
J7326	Hyaluronan or derivative, gel-one, for intra-articular injection, per dose	Prior authorization is required.		
J7327	Hyaluronan or derivative, monovisc, for intra-articular injection, per dose	Prior authorization is required.		
J7328	Hyaluronan or derivative, gelsyn-3, for intra-articular injection, 0.1 mg	Prior authorization is required.		
J7351	Injection, bimatoprost, intracameral implant, 1 microgram	Prior authorization is required.		
J7611	Albuterol, inhalation solution, FDA-approved final product, noncompounded, administered through DME, concentrated form, 1 mg	Need Under 18 no auth required; Prior authorization is required over 18		
J7613	Albuterol, inhalation solution, FDA-approved final product, noncompounded, administered through DME, unit dose, 1 mg	Need Under 18 no auth required; Prior authorization is required over 18		
J7686	Treprostinil, inhalation solution, fda-approved final product, non-compounded, administered through dme, unit dose form, 1.74 mg	Prior authorization is required.		
J7799	NOC drugs, other than inhalation drugs, administered through DME	The following drugs and corresponding NDC codes require prior authorization: Empaveli (73606001001)		
J9029	Injection, nadofaragene firadenovec-vncg, per therapeutic dose	Prior authorization is required.		
J9035	Injection, bevacizumab, 10 mg	Prior authorization is required.		
J9210	Injection, emapalumab-lzsg, 1 mg	Prior authorization is required.		
J9217	Leuprolide acetate (for depot suspension), 7.5 mg	Prior authorization is required.		
J9312	Injection, rituximab, 10 mg	Prior authorization is required.		
J9355	Injection, trastuzumab, excludes biosimilar, 10 mg	Prior authorization is required.		
K0001	STANDARD WHEELCHAIR	Prior authorization is required when the billed charges are greater than $500.		
K0002	STANDARD HEMI WHEELCHAIR	Prior authorization is required when the billed charges are greater than $500.		
K0003	LIGHTWEIGHT WHEELCHAIR	Prior authorization is required when the billed charges are greater than $500.		
K0004	HIGH STRENGTH LIGHTWEIGHT WHLCHAIR	Prior authorization is required when the billed charges are greater than $500.		
K0005	ULTRALIGHTWEIGHT WHEELCHAIR	Prior authorization is required when the billed charges are greater than $500.		
K0006	HEAVY-DUTY WHEELCHAIR	Prior authorization is required when the billed charges are greater than $500.		
K0007	EXTRA HEAVY-DUTY WHEELCHAIR	Prior authorization is required when the billed charges are greater than $500.		
K0008	CUSTOM MANUAL WHEELCHAIR/BASE	Prior authorization is required when the billed charges are greater than $500.		
K0009	OTHER MANUAL WHEELCHAIR/BASE	Prior authorization is required when the billed charges are greater than $500.		

K0010	STD-WT FRME MOTRIZED/PWR WHLCHAIR	Prior authorization is required when the billed charges are greater than $500.		
K0011	STD FRME MOTRIZD WHLCHAIR W/PROG	Prior authorization is required when the billed charges are greater than $500.		
K0012	LGHTWT PRTBLE MOTRIZED/PWR WHLCHAIR	Prior authorization is required when the billed charges are greater than $500.		
K0013	CUSTOM MOTORIZED/POWER WHEELCHAIR B	Prior authorization is required when the billed charges are greater than $500.		
K0014	OTH MOTORIZED/POWER WHEELCHAIR BASE	Prior authorization is required when the billed charges are greater than $500.		
K0015	DETACHBLE NONADJUSTBL HT ARMREST EA	Prior authorization is required when the billed charges are greater than $500.		
K0017	DTACHBLE ADJUST HT ARMREST REPL EA	Prior authorization is required when the billed charges are greater than $500.		
K0018	DTACH ADJ HT ARMRST UP PRTN REPL EA	Prior authorization is required when the billed charges are greater than $500.		
K0019	ARM PAD REPLACEMENT ONLY EACH	Prior authorization is required when the billed charges are greater than $500.		
K0020	FIXED ADJUSTBLE HEIGHT ARMREST PAIR	Prior authorization is required when the billed charges are greater than $500.		
K0037	HIGH MOUNT FLIP-UP FOOTREST EACH	Prior authorization is required when the billed charges are greater than $500.		
K0038	LEG STRAP EACH	Prior authorization is required when the billed charges are greater than $500.		
K0039	LEG STRAP H STYLE EACH	Prior authorization is required when the billed charges are greater than $500.		
K0040	ADJUSTABLE ANGLE FOOTPLATE EACH	Prior authorization is required when the billed charges are greater than $500.		
K0041	LARGE SIZE FOOTPLATE EACH	Prior authorization is required when the billed charges are greater than $500.		
K0042	STANDARD SIZE FOOTPLTE REPL ONLY EA	Prior authorization is required when the billed charges are greater than $500.		
K0043	FOOTREST LWR EXT TUBE REPL ONLY EA	Prior authorization is required when the billed charges are greater than $500.		
K0044	FOOTREST UPR HGR BRKT REPL ONLY EA	Prior authorization is required when the billed charges are greater than $500.		
K0045	FOOTREST CMPL ASSEMBLY REPL ONLY EA	Prior authorization is required when the billed charges are greater than $500.		
K0046	ELEVAT LEGRST L EXT TUBE RPL ONLY E	Prior authorization is required when the billed charges are greater than $500.		
K0047	ELEVT LEGRST UP HGR BRKT RPL ONLY E	Prior authorization is required when the billed charges are greater than $500.		
K0050	RATCHET ASSEMBLY REPLACEMENT ONLY	Prior authorization is required when the billed charges are greater than $500.		
K0051	CAM RLS ASSM FTRST/LGRST RPL ONLY E	Prior authorization is required when the billed charges are greater than $500.		
K0052	SWNGAWAY DTACHBLE FTRSTS RPL ONLY E	Prior authorization is required when the billed charges are greater than $500.		
K0053	ELEVATING FOOTRESTS ARTICULATING EA	Prior authorization is required when the billed charges are greater than $500.		
K0056	SEAT HT<17/=>21 IN LTWT/ULTRLT WC	Prior authorization is required when the billed charges are greater than $500.		
K0065	SPOKE PROTECTORS EACH	Prior authorization is required when the billed charges are greater than $500.		
K0069	RW ASM CMPL SOLID T SPKE/MLD RPL EA	Prior authorization is required when the billed charges are greater than $500.		
K0070	RW ASM CMP PN T SPKS/MLD RPL ONLY E	Prior authorization is required when the billed charges are greater than $500.		
K0071	FRT C ASM COMPL PN TIRE REPL ONLY E	Prior authorization is required when the billed charges are greater than $500.		
K0072	FRT C ASM CMPL SEMIPN T RPL ONLY E	Prior authorization is required when the billed charges are greater than $500.		
K0073	CASTER PIN LOCK EACH	Prior authorization is required when the billed charges are greater than $500.		
K0077	FRT C ASM CMPL SLD TIRE REPL ONLY E	Prior authorization is required when the billed charges are greater than $500.		
K0098	DRIVE BELT FOR POWER WC REPL ONLY	Prior authorization is required when the billed charges are greater than $500.		
K0105	IV HANGER EACH	Prior authorization is required when the billed charges are greater than $500.		
K0108	Wheelchair component or accessory, not otherwise specified	Prior authorization is required for billed charges greater than $500.		
K0195	ELEVATING LEGREST PAIR	Prior authorization is required when the billed charges are greater than $500.		
K0455	INFUS PUMP UNINTRPT PARNTRAL MED	Prior authorization is required when the billed charges are greater than $500.		
K0462	TEMP REPL PT EQUIP REPR ANY TYPE	Prior authorization is required when the billed charges are greater than $500.		
K0552	Supplies for external noninsulin drug infusion pump, syringe type cartridge, sterile, each	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1134 Portable External Infusion Pump	
K0553	SPL ALLOW TX CGM1 MO SPL = 1 U SRVC	Prior authorization is required when the billed charges are greater than $500.		
K0554	RECEIVER DEDICATED TX GCM SYS	Prior authorization is required when the billed charges are greater than $500.		
K0601	Replacement battery for external infusion pump owned by patient, silver oxide, 1.5 volt, each	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1134 Portable External Infusion Pump	
K0602	Replacement battery for external infusion pump owned by patient, silver oxide, 3 volt, each	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1134 Portable External Infusion Pump	
K0603	Replacement battery for external infusion pump owned by patient, alkaline, 1.5 volt, each	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1134 Portable External Infusion Pump	
K0604	Replacement battery for external infusion pump owned by patient, lithium, 3.6 volt, each	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1134 Portable External Infusion Pump	
K0605	Replacement battery for external infusion pump owned by patient, lithium, 4.5 volt, each	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1134 Portable External Infusion Pump	
K0606	Automatic external defibrillator, with integrated electrocardiogram analysis, garment type	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1138 Wearable Cardioverter-Defibrillator	
K0607	REPL BATTERY AUTO EXT DEFIB EA	Prior authorization is required when the billed charges are greater than $500.		
K0608	REPL GARMNT W/AUTO EXT DEFIB EA	Prior authorization is required when the billed charges are greater than $500.		
K0609	REPL ELECTRODE W/AUTO EXT DEFIB EA	Prior authorization is required when the billed charges are greater than $500.		
K0669	WC ACCSS SEAT/BK CUSHN NO DME PDAC	Prior authorization is required when the billed charges are greater than $500.		
K0672	ADD LOW EXT ORTHOSIS REPL EACH	Prior authorization is required when the billed charges are greater than $500.		
K0730	CNTRL DOSE INHAL RX DEL ERY SYS	Prior authorization is required when the billed charges are greater than $500.		
K0733	PWR WC 12-24 AMP HR LEAD BATT EACH	Prior authorization is required when the billed charges are greater than $500.		
K0738	PORT GASEOUS O2 SYS RNTL;HOM COMPRS	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1072 Oxygen and HHO-DE-MP-1030 Home Oxygen Therapy	
K0739	REPR/SRVC DME NOT O2 PER 15 MINS	Prior authorization is required when the billed charges are greater than $500.		
K0740	REPR/SRVC O2 EQP TECH PER 15 MINS	Prior authorization is required when the billed charges are greater than $500.		
K0743	SX PUMP HOME MDL PORT FOR WOUNDS	Prior authorization is required when the billed charges are greater than $500.		
K0744	ABSRB WD DR H MDL PAD 16 SQ IN/LESS	Prior authorization is required when the billed charges are greater than $500.		
K0745	ABS WD DR PAD>16 SQ IN</= 48 SQ IN	Prior authorization is required when the billed charges are greater than $500.		

K0746	ABSRB WD DR H MDL PAD SZ >48 SQ IN	Prior authorization is required when the billed charges are greater than $500.		
K0800	PWR OP VEH GRP 1 STD PT TO 300 LBS	Prior authorization is required when the billed charges are greater than $500.		
K0801	PWR OP VEH GRP 1 HVY PT 301-450 LBS	Prior authorization is required when the billed charges are greater than $500.		
K0802	PWR OP VEH GRP 1 HVY PT 451-600 LBS	Prior authorization is required when the billed charges are greater than $500.		
K0806	PWR OP VEH GRP 2 STD PT TO 300 LBS	Prior authorization is required when the billed charges are greater than $500.		
K0807	PWR OP VEH GRP 2 HVY PT 301-450 LBS	Prior authorization is required when the billed charges are greater than $500.		
K0808	PWR OP VEH GRP 2 PT 451-600 LBS	Prior authorization is required when the billed charges are greater than $500.		
K0812	Power operated vehicle, not otherwise classified	Prior authorization is required for billed charges greater than $500.		
K0813	PWR WC GRP 1 SLING SEAT PT TO 300	Prior authorization is required when the billed charges are greater than $500.		
K0814	PWR WC GRP 1 CAPT CHAIR PT TO 300	Prior authorization is required when the billed charges are greater than $500.		
K0815	PWR WC GRP 1 SLING PT UP TO 300	Prior authorization is required when the billed charges are greater than $500.		
K0816	PWR WC GRP 1 CAPT CHAIR PT TO 300	Prior authorization is required when the billed charges are greater than $500.		
K0820	PWR WC GRP 2 SLING SEAT PT TO 300	Prior authorization is required when the billed charges are greater than $500.		
K0821	PWR WC GRP 2 CAPT CHAIR TO 300	Prior authorization is required when the billed charges are greater than $500.		
K0822	PWR WC GRP 2 SLING SEAT PT TO 300	Prior authorization is required when the billed charges are greater than $500.		
K0823	PWR WC GRP 2 CAPT CHAIR PT TO 300	Prior authorization is required when the billed charges are greater than $500.		
K0824	PWR WC GRP 2 SLING SEAT PT 301-450	Prior authorization is required when the billed charges are greater than $500.		
K0825	PWR WC GRP 2 CAPT CHAIR PT 301-450	Prior authorization is required when the billed charges are greater than $500.		
K0826	PWR WC GRP 2 SLING SEAT PT 451-600	Prior authorization is required when the billed charges are greater than $500.		
K0827	PWR WC GRP 2 CAPT CHAIR PT 451-600	Prior authorization is required when the billed charges are greater than $500.		
K0828	PWR WC GRP 2 SLING SEAT PT 601/>	Prior authorization is required when the billed charges are greater than $500.		
K0829	PWR WC GRP 2X HVY DUTY CHR PT 601/>	Prior authorization is required when the billed charges are greater than $500.		
K0830	PWR WC 2 SEAT ELEV SLING PT TO 300	Prior authorization is required when the billed charges are greater than $500.		
K0831	PWR WC 2 SEAT ELEV CAPT PT TO 300	Prior authorization is required when the billed charges are greater than $500.		
K0835	PWR WC GRP 2 1 PWR SLING PT TO 300	Prior authorization is required when the billed charges are greater than $500.		
K0836	PWR WC 2 1 PWR CAPT CHAIR PT TO 300	Prior authorization is required when the billed charges are greater than $500.		
K0837	PWR WC GRP 2 1 PWR SLING PT 301-450	Prior authorization is required when the billed charges are greater than $500.		
K0838	PWR WC 2 1 PWR CAPT CHR PT 301-450	Prior authorization is required when the billed charges are greater than $500.		
K0839	PWR WC 2 1 PWR SLNG SEAT PT 451-600	Prior authorization is required when the billed charges are greater than $500.		
K0840	PWR WC GRP 2 1 PWR SLING PT 601/>	Prior authorization is required when the billed charges are greater than $500.		
K0841	PWR WC GRP 2 MX PWR SLING PT TO 300	Prior authorization is required when the billed charges are greater than $500.		
K0842	PWR WC 2 MX PWR CAPT CHR PT TO 300	Prior authorization is required when the billed charges are greater than $500.		
K0843	PWR WC 2 MX PWR SLING PT 301-450	Prior authorization is required when the billed charges are greater than $500.		
K0848	PWR WC GRP 3 SLING SEAT PT TO &=300	Prior authorization is required when the billed charges are greater than $500.		
K0849	PWR WC GRP 3 CAPT CHAIR PT TO &=300	Prior authorization is required when the billed charges are greater than $500.		
K0850	PWR WC GRP 3 SLING SEAT PT 301-450	Prior authorization is required when the billed charges are greater than $500.		
K0851	PWR WC GRP 3 CAPT CHAIR PT 301-450	Prior authorization is required when the billed charges are greater than $500.		
K0852	PWR WC GRP 3 SLING SEAT PT 451-600	Prior authorization is required when the billed charges are greater than $500.		
K0853	PWR WC GRP 3 CAPT CHAIR PT 451-600	Prior authorization is required when the billed charges are greater than $500.		
K0854	PWR WC GRP 3 SLING SEAT PT 601 LB/>	Prior authorization is required when the billed charges are greater than $500.		
K0855	PWR WC GRP 3 CAPT CHAIR PT 601 LB/>	Prior authorization is required when the billed charges are greater than $500.		
K0856	PWR WC 3 1 PWR SLING SEAT PT TO 300	Prior authorization is required when the billed charges are greater than $500.		
K0857	PWR WC 3 1 PWR CAPT CHAIR PT TO 300	Prior authorization is required when the billed charges are greater than $500.		
K0858	PWR WC 3 1 PWR SLNG SEAT PT 301-450	Prior authorization is required when the billed charges are greater than $500.		
K0859	PWR WC 3 1 CAP CHAIR PT 301-450	Prior authorization is required when the billed charges are greater than $500.		
K0860	PWR WC 3 1 PWR SLNG SEAT PT 451-600	Prior authorization is required when the billed charges are greater than $500.		
K0861	PWR WC 3 MX PWR SLNG SEAT PT TO 300	Prior authorization is required when the billed charges are greater than $500.		
K0862	PWR WC 3 MX PWR SLING PT 301-450	Prior authorization is required when the billed charges are greater than $500.		
K0863	PWR WC 3 MX PWR SLING PT 451-600	Prior authorization is required when the billed charges are greater than $500.		
K0864	PWR WC 3 MX PWR SLNG SEAT PT 601/>	Prior authorization is required when the billed charges are greater than $500.		
K0868	PWR WC GRP 4 SLING SEAT PT TO &=300	Prior authorization is required when the billed charges are greater than $500.		
K0869	PWR WC GRP 4 CAPT CHAIR PT TO &=300	Prior authorization is required when the billed charges are greater than $500.		
K0870	PWR WC GRP 4 SLING SEAT PT 301-450	Prior authorization is required when the billed charges are greater than $500.		
K0871	PWR WC GRP 4 SLING SEAT PT 451-600	Prior authorization is required when the billed charges are greater than $500.		
K0877	PWR WC 4 1 PWR SLING SEAT PT TO 300	Prior authorization is required when the billed charges are greater than $500.		
K0878	PWR WC 4 1 PWR CAPT CHAIR PT TO 300	Prior authorization is required when the billed charges are greater than $500.		
K0879	PWR WC 4 1 PWR SLNG SEAT PT 301-450	Prior authorization is required when the billed charges are greater than $500.		
K0880	PWR WC 4 1 PWR SLNG SEAT PT 451-600	Prior authorization is required when the billed charges are greater than $500.		
K0884	PWR WC 4 MX PWR SLNG SEAT PT TO 300	Prior authorization is required when the billed charges are greater than $500.		
K0885	PWR WC 4 MX PWR CAP CHAIR PT TO 300	Prior authorization is required when the billed charges are greater than $500.		
K0886	PWR WC 4 MX PWR SLING PT 301-450	Prior authorization is required when the billed charges are greater than $500.		
K0890	PWR WC 5 PED 1 PWR SLING PT TO 125	Prior authorization is required when the billed charges are greater than $500.		
K0891	PWR WC 5 PED MX PWR SLING PT TO 125	Prior authorization is required when the billed charges are greater than $500.		
K0898	Power wheelchair, not otherwise classified	Prior authorization is required for billed charges greater than $500.		
K0899	PWR MOBILTY DEVC NOT CODED DME PDAC	Prior authorization is required when the billed charges are greater than $500.		
K0900	CUSTOMIZED DME OTH THAN WHEELCHAIR	Prior authorization is required when the billed charges are greater than $500.		
K1001	ELEC POSIT OBS SLEEP APNEA TX SENS	Prior authorization is required when the billed charges are greater than $500.		
K1004	LOW FREQ U/S DIA TX DVC HOME USE	Prior authorization is required when the billed charges are greater than $500.		

K1034	PROV COVID-19 TST NP 1 TST CNT	Prior authorization is required when the billed charges are greater than $500.		
L0112	CRANIL CERV ORTHOS CONGN TORTICOLLI	Prior authorization is required when the billed charges are greater than $500.		
L0113	CRANIL CERV ORTHOS TORTICOLLI PRFB	Prior authorization is required when the billed charges are greater than $500.		
L0120	CERVICAL FLEX NONADJUSTABLE PREFAB	Prior authorization is required when the billed charges are greater than $500.		
L0130	CERV FLXBL THRMOPLSTC COLLR MOLD PT	Prior authorization is required when the billed charges are greater than $500.		
L0140	CERVICAL SEMI-RIGID ADJUSTABLE	Prior authorization is required when the billed charges are greater than $500.		
L0150	CERV SEMI-RIGD ADJUST MOLD CHIN CUP	Prior authorization is required when the billed charges are greater than $500.		
L0160	CERV SEMI-RIGID OCCIP/MAND PREFAB	Prior authorization is required when the billed charges are greater than $500.		
L0170	CERV COLLAR MOLDED PATIENT MODEL	Prior authorization is required when the billed charges are greater than $500.		
L0172	CERV COLLAR SEMI-RIGID FOAM PREFAB	Prior authorization is required when the billed charges are greater than $500.		
L0174	CERV COLLR SEMI-RGD THOR EXT PREFAB	Prior authorization is required when the billed charges are greater than $500.		
L0180	CERV MX POST COLLR SUPPS ADJ	Prior authorization is required when the billed charges are greater than $500.		
L0190	CERV MX POST COLLR ADJ CERV BARS	Prior authorization is required when the billed charges are greater than $500.		
L0200	CERV COLLR ADJ CERV BARS&THOR EXT	Prior authorization is required when the billed charges are greater than $500.		
L0220	THORACIC RIB BELT CUSTOM FABRICATED	Prior authorization is required when the billed charges are greater than $500.		
L0450	TLSO FLEX TRUNK SUPP UP THOR PREFAB	Prior authorization is required when the billed charges are greater than $500.		
L0452	TLSO FLEX TRUNK SUPP UP THOR CUSTOM	Prior authorization is required when the billed charges are greater than $500.		
L0454	TLSO FLEX SC JUNC T-9 PRFAB CUSTOM	Prior authorization is required when the billed charges are greater than $500.		
L0455	TLSO FLEX SC JUNC TO T-9 PREFAB	Prior authorization is required when the billed charges are greater than $500.		
L0456	TLSO FLEX SC SCAP SPN PRFAB CUSTOM	Prior authorization is required when the billed charges are greater than $500.		
L0457	TLSO FLX SC JUNC TRM INF SCAP SPINE	Prior authorization is required when the billed charges are greater than $500.		
L0458	TLSO TRIPLANR 2 SHELL ANT-XIPHOID	Prior authorization is required when the billed charges are greater than $500.		
L0460	TLSO TRIPLANR 2 SHELL ANT-STERNL	Prior authorization is required when the billed charges are greater than $500.		
L0462	TLSO TRIPLANR 3 SHELL ANT-STERNL	Prior authorization is required when the billed charges are greater than $500.		
L0464	TLSO TRIPLANR 4 SHELL ANT-STERNL	Prior authorization is required when the billed charges are greater than $500.		
L0466	TLSO SAGITTAL CONTROL PREFAB CUSTOM	Prior authorization is required when the billed charges are greater than $500.		
L0467	TLSO SAGITTAL CONTROL RIGD PREFAB	Prior authorization is required when the billed charges are greater than $500.		
L0468	TLSO SAGITTAL-CORONAL PREFAB CUSTOM	Prior authorization is required when the billed charges are greater than $500.		
L0469	TLSO SAGITTAL-CORONAL CONTRL PREFAB	Prior authorization is required when the billed charges are greater than $500.		
L0470	TLSO TRIPLANAR FRME&APRON W/STRAP	Prior authorization is required when the billed charges are greater than $500.		
L0472	TLSO TRIPLANAR HYPREXT RIGD FRME	Prior authorization is required when the billed charges are greater than $500.		
L0480	TLSO TRIPLANR 1 PC NO INTERFCE CSTM	Prior authorization is required when the billed charges are greater than $500.		
L0482	TLSO TRIPLANAR 1 PC W/INTERFCE CSTM	Prior authorization is required when the billed charges are greater than $500.		
L0484	TLSO TRIPLANR 2 PC NO INTERFCE CSTM	Prior authorization is required when the billed charges are greater than $500.		
L0486	TLSO TRIPLANAR 2 PC W/INTERFCE CSTM	Prior authorization is required when the billed charges are greater than $500.		
L0488	TLSO TRIPLANR 1 PC W/INTERFCE PRFAB	Prior authorization is required when the billed charges are greater than $500.		
L0490	TLSO SAGIT-CORONAL REINFORCE PRFAB	Prior authorization is required when the billed charges are greater than $500.		
L0491	TLSO 2 RIGID PLASTIC SHELLS PREFAB	Prior authorization is required when the billed charges are greater than $500.		
L0492	TLSO 3 RIGID PLASTIC SHELLS PREFAB	Prior authorization is required when the billed charges are greater than $500.		
L0621	SACROILIAC ORTHOSIS FLEXIBLE PREFAB	Prior authorization is required when the billed charges are greater than $500.		
L0622	SACROILIAC ORTHOSIS FLEXIBLE CUSTOM	Prior authorization is required when the billed charges are greater than $500.		
L0623	SACROILIAC ORTHOSIS RIGID PREFAB	Prior authorization is required when the billed charges are greater than $500.		
L0624	SACROILIAC ORTHOSIS RIGID CUSTOM	Prior authorization is required when the billed charges are greater than $500.		
L0625	LUMBAR ORTHOSIS FLEXIBLE PREFAB	Prior authorization is required when the billed charges are greater than $500.		
L0626	LUMB ORTHOS RIGID POST PREFAB CUSTM	Prior authorization is required when the billed charges are greater than $500.		
L0627	LUMB ORTHOS RIGD A&P PNL PRFAB CSTM	Prior authorization is required when the billed charges are greater than $500.		
L0628	LSO FLEXIBLE PREFAB OFF THE SHELF	Prior authorization is required when the billed charges are greater than $500.		
L0629	LSO FLEXIBLE CUSTOM FABRICATED	Prior authorization is required when the billed charges are greater than $500.		
L0630	LSO SAGIT CONTROL RIGID POST PREFAB	Prior authorization is required when the billed charges are greater than $500.		
L0631	LSO SAGIT CNTRL RIGID POST CUSTOM	Prior authorization is required when the billed charges are greater than $500.		
L0632	LSO SAGIT CNTRL RIGID A&P CUSTOM	Prior authorization is required when the billed charges are greater than $500.		
L0633	LSO SAG-COR CNTRL RIGID POST PREFAB	Prior authorization is required when the billed charges are greater than $500.		
L0634	LSO SAG-COR CNTRL RIGID POST CUSTOM	Prior authorization is required when the billed charges are greater than $500.		
L0635	LSO SAG-COR CNTRL LUMB FLEX PREFAB	Prior authorization is required when the billed charges are greater than $500.		
L0636	LSO SAG-COR CNTRL LUMB FLEX CUSTOM	Prior authorization is required when the billed charges are greater than $500.		
L0637	LSO SAG-COR CNTRL RIGID A&P PREFAB	Prior authorization is required when the billed charges are greater than $500.		
L0638	LSO SAG-COR CNTRL RIGID A&P CUSTOM	Prior authorization is required when the billed charges are greater than $500.		
L0639	LSO SAG-COR CNTRL RIGD SHELL PREFAB	Prior authorization is required when the billed charges are greater than $500.		
L0640	LSO SAG-COR CNTRL RIGD SHELL CUSTOM	Prior authorization is required when the billed charges are greater than $500.		
L0641	LUMB ORTHOS SAGIT CTRL RIGD PST PNL	Prior authorization is required when the billed charges are greater than $500.		
L0642	LUMB ORTHOS SAGIT CTRL ANT POST PNL	Prior authorization is required when the billed charges are greater than $500.		
L0643	LSO SAGITTAL CNTRL RIGID POST PANEL	Prior authorization is required when the billed charges are greater than $500.		
L0648	LSO SAGIT CNTRL RIGD ANT POST PANEL	Prior authorization is required when the billed charges are greater than $500.		
L0649	LSO SAGIT-CORNL CNTRL RIGD PST PANL	Prior authorization is required when the billed charges are greater than $500.		
L0650	LSO SAGIT-CORNL CNTRL ANT PST PANL	Prior authorization is required when the billed charges are greater than $500.		
L0651	LSO SAGIT-CORNL CNTRL RIGD SHLL/PNL	Prior authorization is required when the billed charges are greater than $500.		
L0700	CTLSO ANT-POST-LAT CNTRL MOLD PT	Prior authorization is required when the billed charges are greater than $500.		
L0710	CTLSO-MOLD PT-INTERFACE MATERIAL	Prior authorization is required when the billed charges are greater than $500.		

L0810	HALO PROC CERV HALO IN JACKT VEST	Prior authorization is required when the billed charges are greater than $500.		
L0820	HALO PROC CERV HALO-PLAST BDY JACKT	Prior authorization is required when the billed charges are greater than $500.		
L0830	HALO PROC CERV HALO-MLWAKEE ORTHOS	Prior authorization is required when the billed charges are greater than $500.		
L0859	RINGS&PINS	Prior authorization is required when the billed charges are greater than $500.		
L0861	ADD HALO PROC REPLCMT LINER/INTERFC	Prior authorization is required when the billed charges are greater than $500.		
L0970	TLSO CORSET FRONT	Prior authorization is required when the billed charges are greater than $500.		
L0972	LSO CORSET FRONT	Prior authorization is required when the billed charges are greater than $500.		
L0974	TLSO FULL CORSET	Prior authorization is required when the billed charges are greater than $500.		
L0976	LSO FULL CORSET	Prior authorization is required when the billed charges are greater than $500.		
L0978	AXILLARY CRUTCH EXTENSION	Prior authorization is required when the billed charges are greater than $500.		
L0980	PERONEAL STRAPS PREFAB PAIR	Prior authorization is required when the billed charges are greater than $500.		
L0982	STOCKING SUPPORT GRIPS PREFAB SET 4	Prior authorization is required when the billed charges are greater than $500.		
L0984	PROTECTIVE BODY SOCK PREFAB EACH	Prior authorization is required when the billed charges are greater than $500.		
L0999	Addition to spinal orthosis, not otherwise specified	Prior authorization is required for billed charges greater than $500.		
L1000	CTLSO INCL FURNISH INIT ORTHOS-MDL	Prior authorization is required when the billed charges are greater than $500.		
L1001	CTLS IMMOBILIZER INFANT SZ PREFAB	Prior authorization is required when the billed charges are greater than $500.		
L1005	TENSION BASED SCOLIOSIS ORTHOSIS	Prior authorization is required when the billed charges are greater than $500.		
L1010	ADD CTLSO/SCOLIO ORTHOS AX SLING	Prior authorization is required when the billed charges are greater than $500.		
L1020	ADD CTLSO/SCOLIO ORTHOS KYPHOS PAD	Prior authorization is required when the billed charges are greater than $500.		
L1025	ADD CTLSO/SCOLIO ORTHOS KYPHOS PAD	Prior authorization is required when the billed charges are greater than $500.		
L1030	ADD CTLSO/SCOLIO ORTHOS LUMB PAD	Prior authorization is required when the billed charges are greater than $500.		
L1040	ADD CTLSO/SCOLIO ORTHO LUMB/RIB PAD	Prior authorization is required when the billed charges are greater than $500.		
L1050	ADD CTLSO/SCOLIOS ORTHOS STERNL PAD	Prior authorization is required when the billed charges are greater than $500.		
L1060	ADD CTLSO/SCOLIOS ORTHOS THOR PAD	Prior authorization is required when the billed charges are greater than $500.		
L1070	ADD CTLSO/SCOLIO ORTHO TRPEZUS SLNG	Prior authorization is required when the billed charges are greater than $500.		
L1080	ADD CTLSO/SCOLIOSIS ORTHOSIS OUTRIG	Prior authorization is required when the billed charges are greater than $500.		
L1085	ADD CTLSO/SCOLIO OUTRIG BIL-VRT EXT	Prior authorization is required when the billed charges are greater than $500.		
L1090	ADD CTLSO/SCOLIOS ORTHOS LUMB SLING	Prior authorization is required when the billed charges are greater than $500.		
L1100	ADD CTLSO/SCOLIOS RING PLSTC/LEATHR	Prior authorization is required when the billed charges are greater than $500.		
L1110	ADD CTLSO/SCOLIOS RING MOLD PT MDL	Prior authorization is required when the billed charges are greater than $500.		
L1120	ADD CTLSO SCOLIO ORTHO COVR UPRT EA	Prior authorization is required when the billed charges are greater than $500.		
L1200	TLSO INCL FURNISH INIT ORTHOS ONLY	Prior authorization is required when the billed charges are greater than $500.		
L1210	ADDITION TLSO LATERAL THORACIC EXT	Prior authorization is required when the billed charges are greater than $500.		
L1220	ADDITION TLSO ANT THORACIC EXT	Prior authorization is required when the billed charges are greater than $500.		
L1230	ADD TLSO MLWAKEE TYPE SUPERSTRCT	Prior authorization is required when the billed charges are greater than $500.		
L1240	ADDITION TLSO LUMBAR DEROTATION PAD	Prior authorization is required when the billed charges are greater than $500.		
L1250	ADDITION TO TLSO ANTERIOR ASIS PAD	Prior authorization is required when the billed charges are greater than $500.		
L1260	ADD TLSO ANT THOR DEROTATION PAD	Prior authorization is required when the billed charges are greater than $500.		
L1270	ADDITION TO TLSO ABDOMINAL PAD	Prior authorization is required when the billed charges are greater than $500.		
L1280	ADDITION TO TLSO RIB GUSSET EACH	Prior authorization is required when the billed charges are greater than $500.		
L1290	ADDITION TLSO LAT TROCHANTERIC PAD	Prior authorization is required when the billed charges are greater than $500.		
L1300	OTH SCOLIOS PROC BDY JACKT MOLD PT	Prior authorization is required when the billed charges are greater than $500.		
L1310	OTH SCOLIOSIS PROC POSTOP BDY JACKT	Prior authorization is required when the billed charges are greater than $500.		
L1499	Spinal orthosis, not otherwise specified	Prior authorization is required for billed charges greater than $500.		
L1600	HIP ORTHOS ABDUCT FLX FREJKA PREFAB	Prior authorization is required when the billed charges are greater than $500.		
L1610	HIP ORTHOS ABDUCT CNTRL FLEX PREFAB	Prior authorization is required when the billed charges are greater than $500.		
L1620	HIP ORTHOS ABDUCT FLEX PAVLIK PRFAB	Prior authorization is required when the billed charges are greater than $500.		
L1630	HIP ORTHOSIS ABDUCT CONTRL/SEMI-FLX	Prior authorization is required when the billed charges are greater than $500.		
L1640	HIP ORTHOSIS-PELV BAND/SPRDR BAR	Prior authorization is required when the billed charges are greater than $500.		
L1650	HIP ORTHOSIS ABDUCT CNTRL-STATC ADJ	Prior authorization is required when the billed charges are greater than $500.		
L1652	HIP ORTHOS BIL THI CUFF ADLT PRFAB	Prior authorization is required when the billed charges are greater than $500.		
L1660	HIP ORTHOS ABDUCT CNTRL-STATC PLSTC	Prior authorization is required when the billed charges are greater than $500.		
L1680	HIP ORTHOS DYN PELV CNTRL THI CSTM	Prior authorization is required when the billed charges are greater than $500.		
L1681	Hip orthosis, bilateral hip joints and thigh cuffs, adjustable flexion, extension, abduction control of hip joint, postoperative hip abduction type, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a spec…	Prior authorization is required when the billed charges are greater than $500.		
L1685	HIP ORTHOS POSTOP HIP ABDCT CSTM	Prior authorization is required when the billed charges are greater than $500.		
L1686	HIP ORTHOS POSTOP HIP ABDCT PRFAB	Prior authorization is required when the billed charges are greater than $500.		
L1690	COMB BIL LUMBO-SAC HIP FEM ORTHOS	Prior authorization is required when the billed charges are greater than $500.		
L1700	LEGG PERTHES ORTHOSIS TORONTO CSTM	Prior authorization is required when the billed charges are greater than $500.		
L1710	LEGG PERTHES ORTHOS NEWINGTON CSTM	Prior authorization is required when the billed charges are greater than $500.		
L1720	LEGG PERTHES ORTHO TRILAT TACHDIJAN	Prior authorization is required when the billed charges are greater than $500.		
L1730	LEGG PERTHES ORTHOSIS SCOTTISH RITE	Prior authorization is required when the billed charges are greater than $500.		
L1755	LEGG PERTHES ORTHOS PATTEN BOTTOM	Prior authorization is required when the billed charges are greater than $500.		
L1810	KNEE ORTHOSIS ELASTIC JOINTS PREFAB	Prior authorization is required when the billed charges are greater than $500.		
L1812	KNEE ORTHOSIS ELASTIC W/JNTS PREFAB	Prior authorization is required when the billed charges are greater than $500.		
L1820	KO ELAST W/CONDYLR PADS&JNT PRFAB	Prior authorization is required when the billed charges are greater than $500.		
L1830	KNEE ORTHOSIS IMMOBLIZER PREFAB	Prior authorization is required when the billed charges are greater than $500.		

L1831	KNEE ORTHS LOCK KNEE JNT PSTN ORTHT	Prior authorization is required when the billed charges are greater than $500.		
L1832	KNEE ORTHOS IMMOBLZR ADJUST PREFAB	Prior authorization is required when the billed charges are greater than $500.		
L1833	KNEE ORTHOSIS ADJUST JNT RIGD SUPP	Prior authorization is required when the billed charges are greater than $500.		
L1834	KO W/O KNEE JOINT RIGID CUSTOM FAB	Prior authorization is required when the billed charges are greater than $500.		
L1836	KNEE ORTHOSIS RIGD W/O JOINT PREFAB	Prior authorization is required when the billed charges are greater than $500.		
L1840	KO DEROTATION MED-LAT ACL CSTM FAB	Prior authorization is required when the billed charges are greater than $500.		
L1843	KNEE ORTHOS 1 UPRT THI&CALF PREFAB	Prior authorization is required when the billed charges are greater than $500.		
L1844	KNEE ORTHOS 1 UPRT THI&CALF CUSTOM	Prior authorization is required when the billed charges are greater than $500.		
L1845	KNEE ORTHOS DBL UPRT THI&CALF PRFAB	Prior authorization is required when the billed charges are greater than $500.		
L1846	KNEE ORTHOS DBL UPRT THI&CALF CUSTM	Prior authorization is required when the billed charges are greater than $500.		
L1847	KNEE ORTHOS DBL UPRT ADJ JNT PREFAB	Prior authorization is required when the billed charges are greater than $500.		
L1848	KNEE ORTHOS DBL UPRT AIR SUPP PRFAB	Prior authorization is required when the billed charges are greater than $500.		
L1850	KNEE ORTHOS SWEDISH TYPE PREFAB	Prior authorization is required when the billed charges are greater than $500.		
L1851	KNEE ORTHOS SNG UPRT THIGH & CALF	Prior authorization is required when the billed charges are greater than $500.		
L1852	KNEE ORTHOS DBLE UPRT THIGH & CALF	Prior authorization is required when the billed charges are greater than $500.		
L1860	KO MOD SUPRACNDYLR PROSTH SCKT CSTM	Prior authorization is required when the billed charges are greater than $500.		
L1900	AFO SPRNG WIRE DORSIFLX ASST CSTM	Prior authorization is required when the billed charges are greater than $500.		
L1902	ANK ORTH ANK GAUNTLT/SIM PREFAB OTS	Prior authorization is required when the billed charges are greater than $500.		
L1904	ANK ORTH ANK GAUNTLT/SIM CUSTOM FAB	Prior authorization is required when the billed charges are greater than $500.		
L1906	AFO MX-LIGAMENT ANK SUPT PREFB OTS	Prior authorization is required when the billed charges are greater than $500.		
L1907	ANKLE ORTHOS SUPRAMALLEOLAR CUSTOM	Prior authorization is required when the billed charges are greater than $500.		
L1910	AFO POST 1 BAR CLASP ATTCH SHOE	Prior authorization is required when the billed charges are greater than $500.		
L1920	AFO 1 UPRT W/STAT/ADJ STOP CSTM FAB	Prior authorization is required when the billed charges are greater than $500.		
L1930	AFO PLASTIC/OTH MATERIAL PREFAB	Prior authorization is required when the billed charges are greater than $500.		
L1932	AFO RIGD ANT TIBL CARB FIBR/= PRFAB	Prior authorization is required when the billed charges are greater than $500.		
L1940	ANK FT ORTHOS PLSTC/OTH MATL CSTM	Prior authorization is required when the billed charges are greater than $500.		
L1945	AFO MOLD PLSTC RIGD ANT TIBL CSTM	Prior authorization is required when the billed charges are greater than $500.		
L1950	AFO SPIRAL PLASTIC CUSTOM FAB	Prior authorization is required when the billed charges are greater than $500.		
L1951	ANK FT ORTHOS SPIRAL PLSTC/OTH MATL	Prior authorization is required when the billed charges are greater than $500.		
L1960	AFO POST SOLID ANK PLSTC CSTM FAB	Prior authorization is required when the billed charges are greater than $500.		
L1970	AFO PLASTIC W/ANK JOINT CUSTOM FAB	Prior authorization is required when the billed charges are greater than $500.		
L1971	ANK FT ORTHOS PLSTC/OTH MATL PREFAB	Prior authorization is required when the billed charges are greater than $500.		
L1980	AFO 1 UPRT DORSIFLX SLID STIRUP FAB	Prior authorization is required when the billed charges are greater than $500.		
L1990	AFO DBL UPRT DORSIFLX STIRUP CSTM	Prior authorization is required when the billed charges are greater than $500.		
L2000	KAFO 1 UPRT SOLID STIRUP CSTM	Prior authorization is required when the billed charges are greater than $500.		
L2005	KAFO ANY MATL AUTO RLS ANK JNT CSTM	Prior authorization is required when the billed charges are greater than $500.		
L2006	KAF DVC ANY MATERIAL ADJ CUSTOM FAB	Prior authorization is required when the billed charges are greater than $500.		
L2010	KAFO 1 UPRT STIRUP NO KNEE JNT CSTM	Prior authorization is required when the billed charges are greater than $500.		
L2020	KAFO DBL UPRT STIRUP THI&CALF CSTM	Prior authorization is required when the billed charges are greater than $500.		
L2030	KAFO DBL UPRT STIRUP NO KNEE JNT	Prior authorization is required when the billed charges are greater than $500.		
L2034	KAFO PLSTC MED LAT ROTAT CNTRL CSTM	Prior authorization is required when the billed charges are greater than $500.		
L2035	KAFO FULL PLSTC STAT PED SZ PRFAB	Prior authorization is required when the billed charges are greater than $500.		
L2036	KAFO FULL PLSTC DBL UPRT CSTM FAB	Prior authorization is required when the billed charges are greater than $500.		
L2037	KAFO FULL PLSTC 1 UPRIGHT CSTM FAB	Prior authorization is required when the billed charges are greater than $500.		
L2038	KAFO FULL PLSTC MX-AXIS ANKLE CSTM	Prior authorization is required when the billed charges are greater than $500.		
L2040	HKAFO TORSN CNTRL BIL ROTAT STRAPS	Prior authorization is required when the billed charges are greater than $500.		
L2050	HKAFO BIL TORSION CABLES CSTM FAB	Prior authorization is required when the billed charges are greater than $500.		
L2060	HKAFO BIL TORSION BALL BEAR CSTM	Prior authorization is required when the billed charges are greater than $500.		
L2070	HKAFO UNI ROTAT STRAPS CSTM FAB	Prior authorization is required when the billed charges are greater than $500.		
L2080	HKAFO UNI TORSION CABLE CSTM FAB	Prior authorization is required when the billed charges are greater than $500.		
L2090	HKAFO UNI TORSN CABL BALL BEAR CSTM	Prior authorization is required when the billed charges are greater than $500.		
L2106	AFO TIB FX CAST THERMOPLSTC CSTM	Prior authorization is required when the billed charges are greater than $500.		
L2108	AFO TIB FX CAST ORTHS CSTM	Prior authorization is required when the billed charges are greater than $500.		
L2112	AFO TIB FX ORTHOS SFT PRFAB FIT	Prior authorization is required when the billed charges are greater than $500.		
L2114	AFO TIBL FX ORTHOS SEMI-RIGD PRFAB	Prior authorization is required when the billed charges are greater than $500.		
L2116	AFO TIB FX ORTHOS RIGD PRFAB FIT	Prior authorization is required when the billed charges are greater than $500.		
L2126	KAFO FEM FX CAST THERMOPLSTC CSTM	Prior authorization is required when the billed charges are greater than $500.		
L2128	KAFO FEM FX CAST ORTHOS CSTM FAB	Prior authorization is required when the billed charges are greater than $500.		
L2132	KAFO FEM FX CAST ORTHOS SFT PRFAB	Prior authorization is required when the billed charges are greater than $500.		
L2134	KAFO FEM FX CAST SEMI-RIGD PRFAB	Prior authorization is required when the billed charges are greater than $500.		
L2136	KAFO FEM FX CAST ORTHOS RIGD PRFAB	Prior authorization is required when the billed charges are greater than $500.		
L2180	ADD LW EXTRM ORTH PLSTC SHOE INSRT	Prior authorization is required when the billed charges are greater than $500.		
L2182	ADD LW EXT ORTH DROP LOCK KNEE JNT	Prior authorization is required when the billed charges are greater than $500.		
L2184	ADD LW EXTRM ORTH LTD MOT KNEE JNT	Prior authorization is required when the billed charges are greater than $500.		
L2186	ADD LW EXT ORTH ADJ MOT KNEE JNT	Prior authorization is required when the billed charges are greater than $500.		
L2188	ADD LW EXT FX ORTHOS QUADRILAT BRIM	Prior authorization is required when the billed charges are greater than $500.		
L2190	ADD LOW EXTREM FX ORTHOS WAIST BELT	Prior authorization is required when the billed charges are greater than $500.		
L2192	ADD LW EXT ORTH HIP JNT THI FLNGE	Prior authorization is required when the billed charges are greater than $500.		

L2200	ADD LOW EXTRM LTD ANK MOTION EA JNT	Prior authorization is required when the billed charges are greater than $500.		
L2210	ADD LOW EXTREM DORSIFLX ASST EA JNT	Prior authorization is required when the billed charges are greater than $500.		
L2220	ADD LW EXT DRSFLX&PLNTR ASST EA JNT	Prior authorization is required when the billed charges are greater than $500.		
L2230	ADD LW EXT SPLIT FLAT CALIPR STIRUP	Prior authorization is required when the billed charges are greater than $500.		
L2232	ADD LOW EXT ORTHOS ROCKR BOTTM CSTM	Prior authorization is required when the billed charges are greater than $500.		
L2240	ADD LW EXT ROUND CALIPER&PLAT ATTCH	Prior authorization is required when the billed charges are greater than $500.		
L2250	ADD LW EXT FT PLAT MOLD PT STIRUP	Prior authorization is required when the billed charges are greater than $500.		
L2260	ADD LW EXT REINFORCED SOLID STIRUP	Prior authorization is required when the billed charges are greater than $500.		
L2265	ADD LOW EXTREM LONG TONGUE STIRUP	Prior authorization is required when the billed charges are greater than $500.		
L2270	ADD LW EXT VARUS/VALGUS CORR STRAP	Prior authorization is required when the billed charges are greater than $500.		
L2275	ADD LW EXT VARUS/VULGUS CORR PLSTC	Prior authorization is required when the billed charges are greater than $500.		
L2280	ADD LOW EXTREM MOLDED INNR BOOT	Prior authorization is required when the billed charges are greater than $500.		
L2300	ADD LW EXTRM ABDUCT BAR JNTED ADJ	Prior authorization is required when the billed charges are greater than $500.		
L2310	ADD LOW EXTREM ABDUCT BAR STRAIGHT	Prior authorization is required when the billed charges are greater than $500.		
L2320	ADD LOW EXT NONMOLD LACER CSTM ONLY	Prior authorization is required when the billed charges are greater than $500.		
L2330	ADD LOW EXT LACER MOLD PT CSTM ONLY	Prior authorization is required when the billed charges are greater than $500.		
L2335	ADDITION LOW EXTREM ANT SWING BAND	Prior authorization is required when the billed charges are greater than $500.		
L2340	ADD LW EXTRM PRETIBL SHELL MOLD PT	Prior authorization is required when the billed charges are greater than $500.		
L2350	ADD LW EXT PROSTH TYPE SCKT MOLD PT	Prior authorization is required when the billed charges are greater than $500.		
L2360	ADDITION LOW EXTREM EXT STEEL SHANK	Prior authorization is required when the billed charges are greater than $500.		
L2370	ADDITION LOWER EXTREM PATTEN BOTTOM	Prior authorization is required when the billed charges are greater than $500.		
L2375	ADD LW EXT TORSION CNTRL ANK JNT	Prior authorization is required when the billed charges are greater than $500.		
L2380	ADD LW EXT TORSN CNTRL STRAIT KNEE	Prior authorization is required when the billed charges are greater than $500.		
L2385	ADD LW EXTREM STRAIT KNEE JNT HD EA	Prior authorization is required when the billed charges are greater than $500.		
L2387	ADD LW EXT POLYCNTRC KNEE CSTM KAFO	Prior authorization is required when the billed charges are greater than $500.		
L2390	ADD LW EXTRM OFFSET KNEE JNT EA JNT	Prior authorization is required when the billed charges are greater than $500.		
L2395	ADD LW EXT OFFSET KNEE JNT HD EA	Prior authorization is required when the billed charges are greater than $500.		
L2397	ADD LOW EXTREM ORTHOSIS SUSP SLEEVE	Prior authorization is required when the billed charges are greater than $500.		
L2405	ADDITION KNEE JOINT DROP LOCK EACH	Prior authorization is required when the billed charges are greater than $500.		
L2415	ADD KNEE LOCK-INTEGRATD RLSE EA JNT	Prior authorization is required when the billed charges are greater than $500.		
L2425	ADD KNEE JNT DISC/DIAL LOCK EA JNT	Prior authorization is required when the billed charges are greater than $500.		
L2430	ADD KNEE JNT RATCHT LOCK EXT EA JNT	Prior authorization is required when the billed charges are greater than $500.		
L2492	ADD KNEE LIFT LOOP DROP LOCK RING	Prior authorization is required when the billed charges are greater than $500.		
L2500	ADD LW EXTRM THIGH/WT BEAR RING	Prior authorization is required when the billed charges are greater than $500.		
L2510	ADD LW EXTRM THI/WT BEAR MOLD PT	Prior authorization is required when the billed charges are greater than $500.		
L2520	ADD LW EXTRM THI/WT BEAR CSTM	Prior authorization is required when the billed charges are greater than $500.		
L2525	ADD LW EXT ISCH M-L BRIM MOLD PT	Prior authorization is required when the billed charges are greater than $500.		
L2526	ADD LW EXTRM ISCH M-L BRIM CSTM FIT	Prior authorization is required when the billed charges are greater than $500.		
L2530	ADD LW EXT THI/WT BEAR LACR NONMOLD	Prior authorization is required when the billed charges are greater than $500.		
L2540	ADD LW EXT THI/WT BEAR LACR MOLD PT	Prior authorization is required when the billed charges are greater than $500.		
L2550	ADD LW EXT THI/WT BEAR HI ROLL CUFF	Prior authorization is required when the billed charges are greater than $500.		
L2570	ADD LW EXT PELV HIP JNT CLEVIS	Prior authorization is required when the billed charges are greater than $500.		
L2580	ADD LOW EXTRM PELV CNTRL PELV SLING	Prior authorization is required when the billed charges are greater than $500.		
L2600	ADD LW EXT PELV THRUST BEAR FREE	Prior authorization is required when the billed charges are greater than $500.		
L2610	ADD LW EXT PELV THRUST BEAR LOCK	Prior authorization is required when the billed charges are greater than $500.		
L2620	ADD LW EXT PLV HIP JNT HEVY-DUTY EA	Prior authorization is required when the billed charges are greater than $500.		
L2622	ADD LW EXT PELV HIP JNT ADJ FLX EA	Prior authorization is required when the billed charges are greater than $500.		
L2624	ADD LW EXTRM PELV HIP JNT FLX EXT	Prior authorization is required when the billed charges are greater than $500.		
L2627	ADD LW EXT PELV PLSTC MOLD PT-CABLE	Prior authorization is required when the billed charges are greater than $500.		
L2628	ADD LW EXT PELV METL FRME-CABLES	Prior authorization is required when the billed charges are greater than $500.		
L2630	ADD LW EXTRM PELV BAND&BELT UNI	Prior authorization is required when the billed charges are greater than $500.		
L2640	ADD LW EXTRM PELV BAND&BELT BIL	Prior authorization is required when the billed charges are greater than $500.		
L2650	ADD LW EXTRM PELV&THOR GLUTL PAD EA	Prior authorization is required when the billed charges are greater than $500.		
L2660	ADD LOW EXTREM THOR CNTRL THOR BAND	Prior authorization is required when the billed charges are greater than $500.		
L2670	ADD LW EXTRM THOR CNTRL PARASP UPRT	Prior authorization is required when the billed charges are greater than $500.		
L2680	ADD LW EXT THOR CNTRL LAT SUPP UPRT	Prior authorization is required when the billed charges are greater than $500.		
L2750	ADD LW EXT ORTHOS PLAT CHROME/NICKL	Prior authorization is required when the billed charges are greater than $500.		
L2755	ADD LOW EXT ORTHOS PER SEG CSTM	Prior authorization is required when the billed charges are greater than $500.		
L2760	ADD LOW EXTREM ORTHOSIS EXT-EXT-BAR	Prior authorization is required when the billed charges are greater than $500.		
L2768	ORTHOTIC SIDE BAR DISCNCT DEVC-BAR	Prior authorization is required when the billed charges are greater than $500.		
L2780	ADD LW EXT ORTH NONCORROSIVE BAR	Prior authorization is required when the billed charges are greater than $500.		
L2785	ADD LW EXT ORTHOS DROP LOCK RETN EA	Prior authorization is required when the billed charges are greater than $500.		
L2795	ADD LW EXT ORTH KNEE CNTRL FULL CAP	Prior authorization is required when the billed charges are greater than $500.		
L2800	ADD LOW EXT ORTHOS KNEE CAP CSTM	Prior authorization is required when the billed charges are greater than $500.		
L2810	ADD LW EXT ORTH KNEE CNDYLR PAD	Prior authorization is required when the billed charges are greater than $500.		
L2820	ADD LW EXT ORTH SFT INTRFC BLW KNEE	Prior authorization is required when the billed charges are greater than $500.		
L2830	ADD LW EXT ORTH SFT INTRFC ABV KNEE	Prior authorization is required when the billed charges are greater than $500.		
L2840	ADD LW EXT ORTHOS TIB LEN SOCK FX/=	Prior authorization is required when the billed charges are greater than $500.		

L2850	ADD LW EXT ORTHO FEM LEN SOCK FX/=	Prior authorization is required when the billed charges are greater than $500.		
L2861	ADD LOW EXT JNT KNEE/ANK CSTM EA	Prior authorization is required when the billed charges are greater than $500.		
L2999	Lower extremity orthoses, not otherwise specified	Prior authorization is required for billed charges greater than $500.		
L3000	FT INSRT MOLD UCB TYPE BERKLY SHELL	Prior authorization is required when the billed charges are greater than $500.		
L3001	FOOT INSRT REMV MOLD PT SPENCO EA	Prior authorization is required when the billed charges are greater than $500.		
L3002	FT INSRT REMV MOLD PLASTAZOTE/= EA	Prior authorization is required when the billed charges are greater than $500.		
L3003	FOOT INSRT REMV MOLD SILCON GEL EA	Prior authorization is required when the billed charges are greater than $500.		
L3010	FT INSRT MOLD LNGTUDNL ARCH SUPP EA	Prior authorization is required when the billed charges are greater than $500.		
L3020	FT INSRT REMV MOLD LNGTUDNL SUPP EA	Prior authorization is required when the billed charges are greater than $500.		
L3030	FOOT INSERT REMV FORMED PT FT EA	Prior authorization is required when the billed charges are greater than $500.		
L3031	FOOT INSRT/PLAT REMV ADD LW EXT ORS	Prior authorization is required when the billed charges are greater than $500.		
L3040	FOOT ARCH SUPP PREMOLD LNGTUDNL EA	Prior authorization is required when the billed charges are greater than $500.		
L3050	FOOT ARCH SUPP REMV PREMOLD MT EA	Prior authorization is required when the billed charges are greater than $500.		
L3060	FT ARCH SUPP PREMOLD LNGTUDNL/MT EA	Prior authorization is required when the billed charges are greater than $500.		
L3070	FOOT ARCH SUPP NONREMV LNGTUDNL EA	Prior authorization is required when the billed charges are greater than $500.		
L3080	FT ARCH SUPP NONREMV ATTCH SHOE MT	Prior authorization is required when the billed charges are greater than $500.		
L3090	FT ARCH SUPP NONREMV LNGTUDNL/MT EA	Prior authorization is required when the billed charges are greater than $500.		
L3100	HALLUS-VALGUS NIGHT DYN SPLNT PRFAB	Prior authorization is required when the billed charges are greater than $500.		
L3140	FOOT ABDUCT ROTATION BAR INCL SHOES	Prior authorization is required when the billed charges are greater than $500.		
L3150	FOOT ABDUCT ROTATION BAR W/O SHOES	Prior authorization is required when the billed charges are greater than $500.		
L3160	FOOT ADJUSTBL SHOE-STYLD PSTN DEVC	Prior authorization is required when the billed charges are greater than $500.		
L3161	Foot, adductus positioning device, adjustable	Prior authorization is required when the billed charges are greater than $500.		
L3170	FOOT PLASTC SIL HEEL STAB PREFAB EA	Prior authorization is required when the billed charges are greater than $500.		
L3201	ORTHOPED SHOE OXFRD SUPINATR INFNT	Prior authorization is required when the billed charges are greater than $500.		
L3202	ORTHOPED SHOE OXFRD W/SUPINATR CHLD	Prior authorization is required when the billed charges are greater than $500.		
L3203	ORTHOPED SHOE OXFRD W/SUPINATR JR	Prior authorization is required when the billed charges are greater than $500.		
L3204	ORTHOPED SHOE HITOP SUPINATR INFNT	Prior authorization is required when the billed charges are greater than $500.		
L3206	ORTHOPED SHOE HITOP W/SUPINATR CHLD	Prior authorization is required when the billed charges are greater than $500.		
L3207	ORTHOPED SHOE HITOP W/SUPINATR JR	Prior authorization is required when the billed charges are greater than $500.		
L3208	SURGICAL BOOT EACH INFANT	Prior authorization is required when the billed charges are greater than $500.		
L3209	SURGICAL BOOT EACH CHILD	Prior authorization is required when the billed charges are greater than $500.		
L3211	SURGICAL BOOT EACH JUNIOR	Prior authorization is required when the billed charges are greater than $500.		
L3212	BENESCH BOOT PAIR INFANT	Prior authorization is required when the billed charges are greater than $500.		
L3213	BENESCH BOOT PAIR CHILD	Prior authorization is required when the billed charges are greater than $500.		
L3214	BENESCH BOOT PAIR JUNIOR	Prior authorization is required when the billed charges are greater than $500.		
L3215	ORTHOPED FTWEAR LADIES OXFORD EA	Prior authorization is required when the billed charges are greater than $500.		
L3216	ORTHO FTWEAR LADIES SHOE DPTH INLAY	Prior authorization is required when the billed charges are greater than $500.		
L3217	ORTHOPED FTWEAR LADIES HITOP INLAY	Prior authorization is required when the billed charges are greater than $500.		
L3219	ORTHOPED FTWEAR MENS SHOE OXFORD EA	Prior authorization is required when the billed charges are greater than $500.		
L3221	ORTHOPD FTWEAR MENS SHOE DPTH INLAY	Prior authorization is required when the billed charges are greater than $500.		
L3222	ORTHO FTWEAR MENS HITOP DPTH INLAY	Prior authorization is required when the billed charges are greater than $500.		
L3224	ORTHO FTWEAR WOMAN OXFRD PART BRACE	Prior authorization is required when the billed charges are greater than $500.		
L3225	ORTHO FTWEAR MAN OXFRD PART BRACE	Prior authorization is required when the billed charges are greater than $500.		
L3230	ORTHO FTWEAR CSTM SHOE DEPTH INLAY	Prior authorization is required when the billed charges are greater than $500.		
L3250	ORTHOPED FOOTWEAR CSTM MOLD PROSTH	Prior authorization is required when the billed charges are greater than $500.		
L3251	FOOT SHOE MOLD PT SILCON SHOE EA	Prior authorization is required when the billed charges are greater than $500.		
L3252	FOOT SHOE MOLD PT PLASTAZOTE CSTM	Prior authorization is required when the billed charges are greater than $500.		
L3253	FOOT MOLD SHOE PLASTAZOTE CSTM FIT	Prior authorization is required when the billed charges are greater than $500.		
L3254	NONSTANDARD SIZE OR WIDTH	Prior authorization is required when the billed charges are greater than $500.		
L3255	NONSTANDARD SIZE OR LENGTH	Prior authorization is required when the billed charges are greater than $500.		
L3257	ORTHOPED FOOTWEAR ADD CHRG SPLIT SZ	Prior authorization is required when the billed charges are greater than $500.		
L3260	SURGICAL BOOT/SHOE EACH	Prior authorization is required when the billed charges are greater than $500.		
L3265	PLASTAZOTE SANDAL EACH	Prior authorization is required when the billed charges are greater than $500.		
L3300	LIFT ELEV HEEL TAPERED MTS PER INCH	Prior authorization is required when the billed charges are greater than $500.		
L3310	LIFT ELEV HEEL&SOLE NEOPRENE-INCH	Prior authorization is required when the billed charges are greater than $500.		
L3320	LIFT ELEV HEEL&SOLE CORK PER INCH	Prior authorization is required when the billed charges are greater than $500.		
L3330	LIFT ELEVATION METAL EXTENSION	Prior authorization is required when the billed charges are greater than $500.		
L3332	LIFT ELEV IN SHOE TAPERED TO 1/2 IN	Prior authorization is required when the billed charges are greater than $500.		
L3334	LIFT ELEVATION HEEL PER INCH	Prior authorization is required when the billed charges are greater than $500.		
L3340	HEEL WEDGE SACH	Prior authorization is required when the billed charges are greater than $500.		
L3350	HEEL WEDGE	Prior authorization is required when the billed charges are greater than $500.		
L3360	SOLE WEDGE OUTSIDE SOLE	Prior authorization is required when the billed charges are greater than $500.		
L3370	SOLE WEDGE BETWEEN SOLE	Prior authorization is required when the billed charges are greater than $500.		
L3380	CLUBFOOT WEDGE	Prior authorization is required when the billed charges are greater than $500.		
L3390	OUTFLARE WEDGE	Prior authorization is required when the billed charges are greater than $500.		
L3400	METATARSAL BAR WEDGE ROCKER	Prior authorization is required when the billed charges are greater than $500.		
L3410	METATARSAL BAR WEDGE BETWEEN SOLE	Prior authorization is required when the billed charges are greater than $500.		
L3420	FULL SOLE&HEEL WEDGE BETWEEN SOLE	Prior authorization is required when the billed charges are greater than $500.		

L3430	HEEL COUNTER PLASTIC REINFORCED	Prior authorization is required when the billed charges are greater than $500.		
L3440	HEEL COUNTER LEATHER REINFORCED	Prior authorization is required when the billed charges are greater than $500.		
L3450	HEEL SACH CUSHION TYPE	Prior authorization is required when the billed charges are greater than $500.		
L3455	HEEL NEW LEATHER STANDARD	Prior authorization is required when the billed charges are greater than $500.		
L3460	HEEL NEW RUBBER STANDARD	Prior authorization is required when the billed charges are greater than $500.		
L3465	HEEL THOMAS WITH WEDGE	Prior authorization is required when the billed charges are greater than $500.		
L3470	HEEL THOMAS EXTENDED TO BALL	Prior authorization is required when the billed charges are greater than $500.		
L3480	HEEL PAD AND DEPRESSION FOR SPUR	Prior authorization is required when the billed charges are greater than $500.		
L3485	HEEL PAD REMOVABLE FOR SPUR	Prior authorization is required when the billed charges are greater than $500.		
L3500	ORTHOPED SHOE ADD INSOLE LEATHR	Prior authorization is required when the billed charges are greater than $500.		
L3510	ORTHOPED SHOE ADD INSOLE RUBBER	Prior authorization is required when the billed charges are greater than $500.		
L3520	ORTHO SHOE ADD INSOLE FELT W/LEATHR	Prior authorization is required when the billed charges are greater than $500.		
L3530	ORTHOPEDIC SHOE ADDITION SOLE HALF	Prior authorization is required when the billed charges are greater than $500.		
L3540	ORTHOPEDIC SHOE ADDITION SOLE FULL	Prior authorization is required when the billed charges are greater than $500.		
L3550	ORTHOPED SHOE ADD TOE TAP STANDARD	Prior authorization is required when the billed charges are greater than $500.		
L3560	ORTHOPED SHOE ADD TOE TAP HORSESHOE	Prior authorization is required when the billed charges are greater than $500.		
L3570	ORTHOPED SHOE ADD SPCL EXT INSTEP	Prior authorization is required when the billed charges are greater than $500.		
L3580	ORTHO SHOE ADD CNVRT INSTP-VELC CLO	Prior authorization is required when the billed charges are greater than $500.		
L3590	ORTHO SHOE ADD CONVERT FIRM TO SOFT	Prior authorization is required when the billed charges are greater than $500.		
L3595	ORTHOPEDIC SHOE ADDITION MARCH BAR	Prior authorization is required when the billed charges are greater than $500.		
L3600	TRF ORTHOS 1 SHOE-ANR CALIP PL EXST	Prior authorization is required when the billed charges are greater than $500.		
L3610	TX ORTHOS 1 SHOE-ANOTH CALIP PLT N	Prior authorization is required when the billed charges are greater than $500.		
L3620	TRF ORTHOS 1 SHOE-ANOTH SLD STIR EX	Prior authorization is required when the billed charges are greater than $500.		
L3630	TRNS ORTHOS 1 SHOE-ANOTH SLD STIR N	Prior authorization is required when the billed charges are greater than $500.		
L3640	TRNS ORTHOS SHOE-SHOE DENNS BRWNE B	Prior authorization is required when the billed charges are greater than $500.		
L3649	Orthopedic shoe, modification, addition or transfer, not otherwise specified	Prior authorization is required for billed charges greater than $500.		
L3650	SHOULDER ORTHOS FIG 8 ABDUCT PREFAB	Prior authorization is required when the billed charges are greater than $500.		
L3660	SHOULDER ORTHOS FIG 8 CANVAS PREFAB	Prior authorization is required when the billed charges are greater than $500.		
L3670	SHOULDER ORTHOS ACROMIO/CLAV PREFAB	Prior authorization is required when the billed charges are greater than $500.		
L3671	SO JOINT DESIGN W/O JOINTS CUSTOM	Prior authorization is required when the billed charges are greater than $500.		
L3674	SHOULDER ORTHOSIS ABDUCT PSTN CSTM	Prior authorization is required when the billed charges are greater than $500.		
L3675	SHLDR VEST ABDUCT RESTRAINR PREFAB	Prior authorization is required when the billed charges are greater than $500.		
L3677	SHLDR ORTHOS JNT DSGN PREFAB CUSTOM	Prior authorization is required when the billed charges are greater than $500.		
L3678	SHLDR ORTHOS JNT DSGN NO JNT PREFAB	Prior authorization is required when the billed charges are greater than $500.		
L3702	EO W/O JOINTS CUSTOM FABRICATED	Prior authorization is required when the billed charges are greater than $500.		
L3710	ELB ORTHOS ELASTIC METL JNTS PREFAB	Prior authorization is required when the billed charges are greater than $500.		
L3720	EO DBL UPRT W/CUFF FREE MOT CSTM	Prior authorization is required when the billed charges are greater than $500.		
L3730	EO DBL UPRT-CUFF EXT/FLX ASST CSTM	Prior authorization is required when the billed charges are greater than $500.		
L3740	EO DBL UPRT W/CUFF ADJ LOCK CSTM	Prior authorization is required when the billed charges are greater than $500.		
L3760	EO ADJ POS LOCKING JNT PREFAB ITEM	Prior authorization is required when the billed charges are greater than $500.		
L3761	EO ADJ POS LOCKING JOINT PREFAB OTS	Prior authorization is required when the billed charges are greater than $500.		
L3762	ELBOW ORTHOS RIGID W/O JOINT PREFAB	Prior authorization is required when the billed charges are greater than $500.		
L3763	EWHO RIGID W/O JOINTS CUSTOM FAB	Prior authorization is required when the billed charges are greater than $500.		
L3764	EWHO 1/> NONTORSION JNTS CSTM FAB	Prior authorization is required when the billed charges are greater than $500.		
L3765	EWHFO RIGID W/O JOINTS CUSTOM FAB	Prior authorization is required when the billed charges are greater than $500.		
L3766	EWHFO 1/> NONTORSION JNTS CSTM FAB	Prior authorization is required when the billed charges are greater than $500.		
L3806	WHFO CUSTOM FAB INCL FIT & ADJUST	Prior authorization is required when the billed charges are greater than $500.		
L3807	WHF ORTHOS NO JNT PRFAB CUSTOM FIT	Prior authorization is required when the billed charges are greater than $500.		
L3808	WHF ORTHOSIS RIGID NO JNT; CUSTOM	Prior authorization is required when the billed charges are greater than $500.		
L3809	WHF ORTHO NO JOINTS PREFAB ANY TYPE	Prior authorization is required when the billed charges are greater than $500.		
L3891	ADD UP EXT JNT WRIST/ELB CSTM EA	Prior authorization is required when the billed charges are greater than $500.		
L3900	WHFO DYN FLX HNG WRST DRVN CSTM FAB	Prior authorization is required when the billed charges are greater than $500.		
L3901	WHFO DYN FLX HNG CABLE DRIVEN CSTM	Prior authorization is required when the billed charges are greater than $500.		
L3904	WHFO EXTERNAL POWER ELEC CSTM FAB	Prior authorization is required when the billed charges are greater than $500.		
L3905	WHO 1/> NONTORSION JOINTS CSTM FAB	Prior authorization is required when the billed charges are greater than $500.		
L3906	WHO W/O JOINTS STRAPS CSTM FAB	Prior authorization is required when the billed charges are greater than $500.		
L3908	WRST-HND ORTHOS CNTRL COCK-UP PRFAB	Prior authorization is required when the billed charges are greater than $500.		
L3912	HAND FINGR ORTHOS FINGR CNTRL PRFAB	Prior authorization is required when the billed charges are greater than $500.		
L3913	HFO W/O JOINTS CUSTOM FABRICATED	Prior authorization is required when the billed charges are greater than $500.		
L3915	WH ORTHOS 1/>NONTRSN PRFAB CSTM FIT	Prior authorization is required when the billed charges are greater than $500.		
L3916	WH ORTHOS 1/> NONTORSN JOINT PREFAB	Prior authorization is required when the billed charges are greater than $500.		
L3917	HAND ORTHOSIS MC FX PREFAB CSTM FIT	Prior authorization is required when the billed charges are greater than $500.		
L3918	HAND ORTHOSIS METACARPL FX ORTHOSIS	Prior authorization is required when the billed charges are greater than $500.		
L3919	HAND ORTHOSIS W/O JOINTS CUSTOM FAB	Prior authorization is required when the billed charges are greater than $500.		
L3921	HFO 1/> NONTORSION JOINTS CSTM FAB	Prior authorization is required when the billed charges are greater than $500.		
L3923	HF ORTHOSIS NO JOINT PRFAB CSTM FIT	Prior authorization is required when the billed charges are greater than $500.		
L3924	HAND-FINGER ORTHOSIS W/O JOINTS	Prior authorization is required when the billed charges are greater than $500.		
L3925	FINGER ORTHOS NONTORSION JNT PREFAB	Prior authorization is required when the billed charges are greater than $500.		

L3927	FINGER ORTHOSIS W/O JOINT PREFAB	Prior authorization is required when the billed charges are greater than $500.		
L3929	HF ORTHOS 1/>NONTRSN JNT PRFAB CSTM	Prior authorization is required when the billed charges are greater than $500.		
L3930	HF ORTHOS 1/> NONTORSION JNT PREFAB	Prior authorization is required when the billed charges are greater than $500.		
L3931	WHFO PREFAB INCL FITTING & ADJ	Prior authorization is required when the billed charges are greater than $500.		
L3933	FINGER ORTHOSIS W/O JOINTS CSTM FAB	Prior authorization is required when the billed charges are greater than $500.		
L3935	FO NONTORSION JOINT CUSTOM FAB	Prior authorization is required when the billed charges are greater than $500.		
L3956	ADD JNT UP EXTREM ORTHOS MATL; JNT	Prior authorization is required when the billed charges are greater than $500.		
L3960	SEWHO ABDUCT PSTN AIRPLANE DESIGN	Prior authorization is required when the billed charges are greater than $500.		
L3961	SEWHO SHLDR CAP DESN NO JNTS CSTM	Prior authorization is required when the billed charges are greater than $500.		
L3962	SEWHO ABDUCT PSTN ERBS PALS DESIGN	Prior authorization is required when the billed charges are greater than $500.		
L3967	SEWHO ABDUCT PSTN W/O JNTS CSTM FAB	Prior authorization is required when the billed charges are greater than $500.		
L3971	SEWHO SHOULDER CAP DESIGN CSTM FAB	Prior authorization is required when the billed charges are greater than $500.		
L3973	SEWHO ABDUCTION POSITION CSTM FAB	Prior authorization is required when the billed charges are greater than $500.		
L3975	SEWHFO SHLDR CAP DESN NO JNTS CSTM	Prior authorization is required when the billed charges are greater than $500.		
L3976	SEWHFO ABDUCT PSTN W/O JNTS CUS FAB	Prior authorization is required when the billed charges are greater than $500.		
L3977	SEWHFO SHOULD CAP DESIGN CUSTOM FAB	Prior authorization is required when the billed charges are greater than $500.		
L3978	SEWHFO ABDUCTION POSITION CSTM FAB	Prior authorization is required when the billed charges are greater than $500.		
L3980	UP EXT FX ORTHOS HUM PRFAB-FIT&ADJ	Prior authorization is required when the billed charges are greater than $500.		
L3981	UE FX ORTHOSIS HUMERAL PREF STRAPS	Prior authorization is required when the billed charges are greater than $500.		
L3982	UP EXTRM FX ORTH RADUS/ULNAR PRFAB	Prior authorization is required when the billed charges are greater than $500.		
L3984	UP EXTRM FX ORTHOSIS WRST PRFAB	Prior authorization is required when the billed charges are greater than $500.		
L3995	ADD UP EXTREM ORTHOS SOCK FX/= EA	Prior authorization is required when the billed charges are greater than $500.		
L3999	Upper limb orthosis, not otherwise specified	Prior authorization is required for billed charges greater than $500.		
L4000	REPLACE GIRDLE FOR SPINAL ORTHOSIS	Prior authorization is required when the billed charges are greater than $500.		
L4002	REPL STRAP ANY ORTHOSIS ALL CMPNTS	Prior authorization is required when the billed charges are greater than $500.		
L4010	REPLACE TRILATERAL SOCKET BRIM	Prior authorization is required when the billed charges are greater than $500.		
L4020	REPL QUADRILAT SOCKT BRIM MOLD PT	Prior authorization is required when the billed charges are greater than $500.		
L4030	REPL QUADRILAT SOCKT BRIM CSTM FIT	Prior authorization is required when the billed charges are greater than $500.		
L4040	REPL MOLDED THI LACER CSTM ONLY	Prior authorization is required when the billed charges are greater than $500.		
L4045	REPL NONMOLD THI LACER CSTM ONLY	Prior authorization is required when the billed charges are greater than $500.		
L4050	REPL MOLDED CALF LACER CSTM ONLY	Prior authorization is required when the billed charges are greater than $500.		
L4055	REPL NONMOLD CALF LACER CSTM ONLY	Prior authorization is required when the billed charges are greater than $500.		
L4060	REPLACE HIGH ROLL CUFF	Prior authorization is required when the billed charges are greater than $500.		
L4070	REPLACE PROXIMAL&DIST UPRIGHT KAFO	Prior authorization is required when the billed charges are greater than $500.		
L4080	REPLACE METAL BANDS KAFO PROX THIGH	Prior authorization is required when the billed charges are greater than $500.		
L4090	REPL METL BANDS KAFO-AFO CALF/THI	Prior authorization is required when the billed charges are greater than $500.		
L4100	REPLACE LEATHR CUFF KAFO PROX THIGH	Prior authorization is required when the billed charges are greater than $500.		
L4110	REPL LEATHR CUFF KAFO-AFO CALF/THI	Prior authorization is required when the billed charges are greater than $500.		
L4130	REPLACE PRETIBIAL SHELL	Prior authorization is required when the billed charges are greater than $500.		
L4205	REPR ORTHOT DEVC LABR CMPNT 15 MIN	Prior authorization is required when the billed charges are greater than $500.		
L4210	Repair orthotic device	Prior authorization is required for billed charges greater than $500.		
L4350	ANKLE CONTROL ORTHOS STIRRUP PREFAB	Prior authorization is required when the billed charges are greater than $500.		
L4360	WALK BOOT PNEUMAT&/VAC PREFAB CUSTM	Prior authorization is required when the billed charges are greater than $500.		
L4361	WALKING BOOT PNEUMATIC AND/OR VAC	Prior authorization is required when the billed charges are greater than $500.		
L4370	PNEUMATIC FULL LEG SPLINT PREFAB	Prior authorization is required when the billed charges are greater than $500.		
L4386	WALK BOOT NON-PNEUMATIC PREFAB CSTM	Prior authorization is required when the billed charges are greater than $500.		
L4387	WALKING BOOT NON-PNEUMATIC PREFAB	Prior authorization is required when the billed charges are greater than $500.		
L4392	REPLCMT SFT INTERFCE MATL STAT AFO	Prior authorization is required when the billed charges are greater than $500.		
L4394	REPL SFT INTRFCE MATL FT DROP SPLNT	Prior authorization is required when the billed charges are greater than $500.		
L4396	STAT/DYN ANK FT ORTHOS PREFAB CSTM	Prior authorization is required when the billed charges are greater than $500.		
L4397	STATIC/DYNAMIC AFO MIN ABM PREFAB	Prior authorization is required when the billed charges are greater than $500.		
L4398	FOOT DROP SPLINT RECUMBNT POS PRFAB	Prior authorization is required when the billed charges are greater than $500.		
L4631	AFO WALK BOOT TYP ROCKR BOTTOM CSTM	Prior authorization is required when the billed charges are greater than $500.		
L5000	PART FT SHOE INSRT W/LNGTUDNL ARCH	Prior authorization is required when the billed charges are greater than $500.		
L5010	PART FT MOLD SOCKT ANK HT W/TOE FIL	Prior authorization is required when the billed charges are greater than $500.		
L5020	PART FT MOLD SOCKET TIB TUBERCLE HT	Prior authorization is required when the billed charges are greater than $500.		
L5050	ANKLE SYMES MOLDED SOCKET SACH FOOT	Prior authorization is required when the billed charges are greater than $500.		
L5060	ANK SYMS METL FRME MOLD LEATHR SCKT	Prior authorization is required when the billed charges are greater than $500.		
L5100	BELW KNEE MOLD SOCKT SHIN SACH FOOT	Prior authorization is required when the billed charges are greater than $500.		
L5105	BK PLSTC SCKT JNT&THI LACER SACH FT	Prior authorization is required when the billed charges are greater than $500.		
L5150	KNEE DISRTC MOLD SCKT EXT KNEE JNT	Prior authorization is required when the billed charges are greater than $500.		
L5160	KNEE DISARTIC MOLD SOCKT BENT KNEE	Prior authorization is required when the billed charges are greater than $500.		
L5200	AK MOLD SOCKT 1 AXIS CONSTANT FRICT	Prior authorization is required when the billed charges are greater than $500.		
L5210	AK SHRT PROS NO KNEE JNT-ANK JNT EA	Prior authorization is required when the billed charges are greater than $500.		
L5220	AK SHRT PROSTH W/ARTIC ANK/FOOT DYN	Prior authorization is required when the billed charges are greater than $500.		
L5230	AK PROX FEM FOCAL DEFIC SACH FOOT	Prior authorization is required when the billed charges are greater than $500.		
L5250	HIP DISRTC CANADIAN; MOLD SCKT HIP	Prior authorization is required when the billed charges are greater than $500.		
L5270	HIP DISRTC TLT TABL; MOLD SCKT LOCK	Prior authorization is required when the billed charges are greater than $500.		

L5280	HEMIPELVECT CANADIAN; MOLD SOCKT	Prior authorization is required when the billed charges are greater than $500.		
L5301	BK MOLD SCKT SHIN SACH FT ENDO SYS	Prior authorization is required when the billed charges are greater than $500.		
L5312	KNEE DISART MOLD SOCKET 1 AXIS KNEE	Prior authorization is required when the billed charges are greater than $500.		
L5321	AK OPEN END SACH FT ENDO SYS 1 AXIS	Prior authorization is required when the billed charges are greater than $500.		
L5331	JOINT SINGLE AXIS KNEE SACH FOOT	Prior authorization is required when the billed charges are greater than $500.		
L5341	SINGLE AXIS KNEE SACH FOOT	Prior authorization is required when the billed charges are greater than $500.		
L5400	IMMED POSTSURG RIGD DRSG W/1 CHG BK	Prior authorization is required when the billed charges are greater than $500.		
L5410	IMMED POSTSURG RIGD DRS BK-EA CAST	Prior authorization is required when the billed charges are greater than $500.		
L5420	IMMED POSTSURG RIGD DRSG 1 CHG AK	Prior authorization is required when the billed charges are greater than $500.		
L5430	IMMED POSTSURG RIGD DRSG AK EA CAST	Prior authorization is required when the billed charges are greater than $500.		
L5450	IMMED POSTSURG NONWT BEAR RIGD BK	Prior authorization is required when the billed charges are greater than $500.		
L5460	IMMED POSTSURG NONWT BEAR RIGD AK	Prior authorization is required when the billed charges are greater than $500.		
L5500	INIT BK PTB SCKT NON-ALIGN DIR FORM	Prior authorization is required when the billed charges are greater than $500.		
L5505	INIT AK-DISRTC ISCH LEVL NON-ALIGN	Prior authorization is required when the billed charges are greater than $500.		
L5510	PREP BK PTB SCKT NON-ALIGN MOLD MDL	Prior authorization is required when the billed charges are greater than $500.		
L5520	PREP BK PTB THERMOPLSTC/=DIR FORM	Prior authorization is required when the billed charges are greater than $500.		
L5530	PREP BK PTB THERMOPLSTC/=MOLD MODEL	Prior authorization is required when the billed charges are greater than $500.		
L5535	PREP BK PTB PRFAB ADJ OPEN END SCKT	Prior authorization is required when the billed charges are greater than $500.		
L5540	PREP BK PTB LAMINATED SCKT MOLD MDL	Prior authorization is required when the billed charges are greater than $500.		
L5560	PREP AK-DISARTIC PLASTER MOLD MODEL	Prior authorization is required when the billed charges are greater than $500.		
L5570	PREP AK-DISRTC THRMOPLSTC/=DIR FORM	Prior authorization is required when the billed charges are greater than $500.		
L5580	PREP AK-DISARTIC THERMOPLSTC/=MOLD	Prior authorization is required when the billed charges are greater than $500.		
L5585	PREP AK-DISARTIC PRFAB ADJ OPEN END	Prior authorization is required when the billed charges are greater than $500.		
L5590	PREP AK-DISARTC LAMINATD SCKT MOLD	Prior authorization is required when the billed charges are greater than $500.		
L5595	PREP HIP DISARTC THERMOPLSTC/=MOLD	Prior authorization is required when the billed charges are greater than $500.		
L5600	PREP HIP DISARTC LAMINATD SCKT MOLD	Prior authorization is required when the billed charges are greater than $500.		
L5610	ADD LOW EXTRM ENDO AK HYDRACADENCE	Prior authorization is required when the billed charges are greater than $500.		
L5611	ADD LW EXT AK-DISARTC W/FRICT CNTRL	Prior authorization is required when the billed charges are greater than $500.		
L5613	ADD LW EXT AK-DSRTC W/HYDRAUL CNTRL	Prior authorization is required when the billed charges are greater than $500.		
L5614	ADD LW EXT AK-DSRTC W/PNEUMAT CNTRL	Prior authorization is required when the billed charges are greater than $500.		
L5615	Addition, endoskeletal knee-shin system, 4 bar linkage or multiaxial, fluid swing and stance phase control	Prior authorization is required when the billed charges are greater than $500.		
L5616	ADD LOW EXT AK UNIVRSL MXPLX FRICT	Prior authorization is required when the billed charges are greater than $500.		
L5617	ADD LW EXTREM QUICK CHANGE AK/BK EA	Prior authorization is required when the billed charges are greater than $500.		
L5618	ADD LOW EXTREM TEST SOCKT SYMES	Prior authorization is required when the billed charges are greater than $500.		
L5620	ADD LOW EXTREM TEST SOCKT BELW KNEE	Prior authorization is required when the billed charges are greater than $500.		
L5622	ADD LW EXTRM TST SOCKT KNEE DISARTC	Prior authorization is required when the billed charges are greater than $500.		
L5624	ADD LOW EXTREM TEST SOCKT ABVE KNEE	Prior authorization is required when the billed charges are greater than $500.		
L5626	ADD LW EXTRM TST SOCKT HIP DISARTIC	Prior authorization is required when the billed charges are greater than $500.		
L5628	ADD LOW EXTRM TST SOCKT HEMIPELVECT	Prior authorization is required when the billed charges are greater than $500.		
L5629	ADD LW EXTRM BELW KNEE ACRYLC SOCKT	Prior authorization is required when the billed charges are greater than $500.		
L5630	ADD LW EXT SYMS TYPE XPND WALL SCKT	Prior authorization is required when the billed charges are greater than $500.		
L5631	ADD LW EXT ABVE KNEE/DISARTC ACRYLC	Prior authorization is required when the billed charges are greater than $500.		
L5632	ADD LW EXT SYMS PTB BRIM DESN SOCKT	Prior authorization is required when the billed charges are greater than $500.		
L5634	ADD LW EXT SYMS POST OPENING SOCKT	Prior authorization is required when the billed charges are greater than $500.		
L5636	ADD LW EXT SYMS MED OPENING SOCKT	Prior authorization is required when the billed charges are greater than $500.		
L5637	ADD LOW EXTREM BELW KNEE TOTAL CNTC	Prior authorization is required when the billed charges are greater than $500.		
L5638	ADD LW EXTRM BELW KNEE LEATHR SOCKT	Prior authorization is required when the billed charges are greater than $500.		
L5639	ADD LOW EXTREM BELW KNEE WOOD SOCKT	Prior authorization is required when the billed charges are greater than $500.		
L5640	ADD LW EXT KNEE DISARTC LEATHR SCKT	Prior authorization is required when the billed charges are greater than $500.		
L5642	ADD LW EXTRM ABVE KNEE LEATHR SOCKT	Prior authorization is required when the billed charges are greater than $500.		
L5643	ADD LW EXT HIP DISRTC FLX EXT FRAME	Prior authorization is required when the billed charges are greater than $500.		
L5644	ADD LOW EXTREM ABVE KNEE WOOD SOCKT	Prior authorization is required when the billed charges are greater than $500.		
L5645	ADD LOW EXTRM BK FLX INNR EXT FRME	Prior authorization is required when the billed charges are greater than $500.		
L5646	ADD LOW EXT BELOW KNEE CUSHN SOCKT	Prior authorization is required when the billed charges are greater than $500.		
L5647	ADD LOW EXTRM BELW KNEE SUCTN SOCKT	Prior authorization is required when the billed charges are greater than $500.		
L5648	ADD LOW EXT ABOVE KNEE CUSHN SOCKET	Prior authorization is required when the billed charges are greater than $500.		
L5649	ADD LW EXT ISCHIAL CONTAINMENT SCKT	Prior authorization is required when the billed charges are greater than $500.		
L5650	ADD LW EXTRM TOT CONTACT AK/DISARTC	Prior authorization is required when the billed charges are greater than $500.		
L5651	ADD LOW EXTRM AK FLX INNR EXT FRME	Prior authorization is required when the billed charges are greater than $500.		
L5652	ADD LOW EXTRM SUCTN SUSP AK/DISARTC	Prior authorization is required when the billed charges are greater than $500.		
L5653	ADD LW EXT KNEE DISRTC XPNDABL WALL	Prior authorization is required when the billed charges are greater than $500.		
L5654	ADD LOW EXTREM SOCKT INSERT SYMES	Prior authorization is required when the billed charges are greater than $500.		
L5655	ADD LOW EXTRM SOCKT INSRT BELW KNEE	Prior authorization is required when the billed charges are greater than $500.		
L5656	ADD LW EXT SOCKT INSRT KNEE DISARTC	Prior authorization is required when the billed charges are greater than $500.		
L5658	ADD LOW EXTRM SOCKT INSRT ABVE KNEE	Prior authorization is required when the billed charges are greater than $500.		
L5661	ADD LW EXT INSRT MXIDUROMETER SYMES	Prior authorization is required when the billed charges are greater than $500.		
L5665	ADD LW EXT INSRT MXDROMTR BELW KNEE	Prior authorization is required when the billed charges are greater than $500.		

L5666	ADD LOW EXTREM BELOW KNEE CUFF SUSP	Prior authorization is required when the billed charges are greater than $500.		
L5668	ADD LW EXTRM BK MOLD DISTAL CUSHION	Prior authorization is required when the billed charges are greater than $500.		
L5670	ADD LW EXTRM BK MOLD SUPRACOND SUSP	Prior authorization is required when the billed charges are greater than $500.		
L5671	ADD LOW EXTRM BK/AK SUSP LOCK MECH	Prior authorization is required when the billed charges are greater than $500.		
L5672	ADD LOW EXTRM BK REMV MED BRIM SUSP	Prior authorization is required when the billed charges are greater than $500.		
L5673	ADD LOW EXT BK/AK CSTM FAB XST MOLD	Prior authorization is required when the billed charges are greater than $500.		
L5676	ADD LOW EXT BK KNEE JNT 1 AXIS PAIR	Prior authorization is required when the billed charges are greater than $500.		
L5677	ADD LW EXT BK KNEE JNT POLYCNTRC PR	Prior authorization is required when the billed charges are greater than $500.		
L5678	ADD LW EXT BELW KNEE JNT COVRS PAIR	Prior authorization is required when the billed charges are greater than $500.		
L5679	ADD LOW EXT BK/AK CSTM FAB XST MOLD	Prior authorization is required when the billed charges are greater than $500.		
L5680	ADD LOW EXTRM BK THI LACER NONMOLD	Prior authorization is required when the billed charges are greater than $500.		
L5681	ADD LW EXT BK/AK CONGN/AMPUTEE INIT	Prior authorization is required when the billed charges are greater than $500.		
L5682	ADD LOW EXTREM BK THIGH LACER MOLD	Prior authorization is required when the billed charges are greater than $500.		
L5683	ADD LOW EXT BK/AK NO CONGN/AMP INIT	Prior authorization is required when the billed charges are greater than $500.		
L5684	ADD LOW EXTREM BELW KNEE FORK STRAP	Prior authorization is required when the billed charges are greater than $500.		
L5685	ADD LOW EXT PROS BELW KNEE SLEEVE	Prior authorization is required when the billed charges are greater than $500.		
L5686	ADD LOW EXTREM BELW KNEE BACK CHECK	Prior authorization is required when the billed charges are greater than $500.		
L5688	ADD LOWER EXTRM BK WAIST BELT WEBNG	Prior authorization is required when the billed charges are greater than $500.		
L5690	ADD LOW EXTRMITY BK WAIST BELT PAD	Prior authorization is required when the billed charges are greater than $500.		
L5692	ADD LW EXTRM AK PELVIC CONTROL BELT	Prior authorization is required when the billed charges are greater than $500.		
L5694	ADD LW EXTRM AK PELV CNTRL BELT PAD	Prior authorization is required when the billed charges are greater than $500.		
L5695	ADD LW EXT AK PELV CNTRL SLV NEOPRN	Prior authorization is required when the billed charges are greater than $500.		
L5696	ADD LOW EXTRM AK/DISARTIC PELV JNT	Prior authorization is required when the billed charges are greater than $500.		
L5697	ADD LOW EXTRM AK/DISARTIC PELV BAND	Prior authorization is required when the billed charges are greater than $500.		
L5698	ADD LW EXTRM AK/KD SILESIAN BANDAGE	Prior authorization is required when the billed charges are greater than $500.		
L5699	ALL LOW EXTREM PROSTH SHLDR HARNESS	Prior authorization is required when the billed charges are greater than $500.		
L5700	REPL SOCKET BELOW KNEE MOLD PT MDL	Prior authorization is required when the billed charges are greater than $500.		
L5701	REPL SCKT AK/DISARTIC W/ ATTCH PLAT	Prior authorization is required when the billed charges are greater than $500.		
L5702	REPL SCKT HIP DISRTC W/HIP JNT MOLD	Prior authorization is required when the billed charges are greater than $500.		
L5703	ANK SYMES MLD PT MDL SACH FT REPL	Prior authorization is required when the billed charges are greater than $500.		
L5704	CUSTOM SHAP PROTVE COVER BELOW KNEE	Prior authorization is required when the billed charges are greater than $500.		
L5705	CUSTOM SHAP PROTVE COVER ABOVE KNEE	Prior authorization is required when the billed charges are greater than $500.		
L5706	CUSTOM SHAPED COVER KNEE DISARTIC	Prior authorization is required when the billed charges are greater than $500.		
L5707	CUSTOM SHAPED COVER HIP DISARTIC	Prior authorization is required when the billed charges are greater than $500.		
L5710	ADD EXOSKL KNEE-SHIN 1 AXS MNL LOCK	Prior authorization is required when the billed charges are greater than $500.		
L5711	ADD EXO KNEE-SHIN MNL LOCK ULTRA-LT	Prior authorization is required when the billed charges are greater than $500.		
L5712	ADD EXO KNEE-SHIN FRICT SWING CNTRL	Prior authorization is required when the billed charges are greater than $500.		
L5714	ADD EXO KNEE-SHIN VARBL FRICT SWING	Prior authorization is required when the billed charges are greater than $500.		
L5716	ADD EXO KNEE-SHIN MECH STANCE LOCK	Prior authorization is required when the billed charges are greater than $500.		
L5718	ADD EXO KNEE-SHIN FRICT SWING CNTRL	Prior authorization is required when the billed charges are greater than $500.		
L5722	ADD EXO KNEE-SHIN PNUMAT SWNG FRICT	Prior authorization is required when the billed charges are greater than $500.		
L5724	ADD KNEE-SHIN 1 AXIS FL SWING PHASE	Prior authorization is required when the billed charges are greater than $500.		
L5726	ADD EXO KNEE-SHIN EXT JNT FL SWING	Prior authorization is required when the billed charges are greater than $500.		
L5728	ADD EXO KNEE-SHIN FL SWING&STANCE	Prior authorization is required when the billed charges are greater than $500.		
L5780	ADD EXO KNEE-SHIN PNEUMAT/HYDRA	Prior authorization is required when the billed charges are greater than $500.		
L5781	ADD LW LIMB PROS LIMB MGMT SYS	Prior authorization is required when the billed charges are greater than $500.		
L5782	ADD LW LIMB PROS LIMB MGMT HVY DUTY	Prior authorization is required when the billed charges are greater than $500.		
L5785	ADD EXOSKEL BELW KNEE ULTRA-LT MATL	Prior authorization is required when the billed charges are greater than $500.		
L5790	ADD EXOSKEL ABVE KNEE ULTRA-LT MATL	Prior authorization is required when the billed charges are greater than $500.		
L5795	ADD EXOSKEL HIP DISARTIC ULTRA-LGHT	Prior authorization is required when the billed charges are greater than $500.		
L5810	ADD ENDOSKEL KNEE-SHIN MANUAL LOCK	Prior authorization is required when the billed charges are greater than $500.		
L5811	ADD ENDO KNEE-SHIN MNL LCK ULTRA-LT	Prior authorization is required when the billed charges are greater than $500.		
L5812	ADD ENDO KNEE-SHIN FRICT SWNG CNTRL	Prior authorization is required when the billed charges are greater than $500.		
L5814	ADD ENDO KNEE-SHN HYDRAUL MECH LOCK	Prior authorization is required when the billed charges are greater than $500.		
L5816	ADD ENDO KNEE-SHIN MECH STANCE LOCK	Prior authorization is required when the billed charges are greater than $500.		
L5818	ADD ENDO KNEE-SHIN FRICT SWNG&STANC	Prior authorization is required when the billed charges are greater than $500.		
L5822	ADD ENDO KNEE-SHIN PNEUMATIC FRICT	Prior authorization is required when the billed charges are greater than $500.		
L5824	ADD ENDO KNEE-SHIN FL SWING CNTRL	Prior authorization is required when the billed charges are greater than $500.		
L5826	ADD ENDO KNEE-SHIN MIN HI ACTV FRME	Prior authorization is required when the billed charges are greater than $500.		
L5828	ADD ENDO KNEE-SHIN FL SWING&STANCE	Prior authorization is required when the billed charges are greater than $500.		
L5830	ADD ENDO KNEE-SHIN PNEUMAT/SWING	Prior authorization is required when the billed charges are greater than $500.		
L5840	ADD ENDO KNEE-SHIN 4-BAR LINK SWING	Prior authorization is required when the billed charges are greater than $500.		
L5845	ADD ENDOSKL KNEE-SHIN STANC FLX ADJ	Prior authorization is required when the billed charges are greater than $500.		
L5848	ADD ENDOSKEL KNEE-SHIN FLUID EXT	Prior authorization is required when the billed charges are greater than $500.		
L5850	ADD ENDO AK/HIP DSRTC KNEE EXT ASST	Prior authorization is required when the billed charges are greater than $500.		
L5855	ADD ENDO HIP DISARTIC MECH EXT ASST	Prior authorization is required when the billed charges are greater than $500.		
L5856	ADD LOW EXT PROS KN-SHN SWING&STNCE	Prior authorization is required when the billed charges are greater than $500.		
L5857	ADD LOW EXT PROS KN-SHN SWING ONLY	Prior authorization is required when the billed charges are greater than $500.		

L5858	ADD LW EXT PROS KNEE SHN SYS STANCE	Prior authorization is required when the billed charges are greater than $500.		
L5859	ADD LW EXT PROS KN-SHN PROG FLX/EXT	Prior authorization is required when the billed charges are greater than $500.		
L5910	ADD ENDOSKEL BELOW KNEE ALIGNBL SYS	Prior authorization is required when the billed charges are greater than $500.		
L5920	ADD ENDOSKEL AK/HIP DISRTC ALIGNBL	Prior authorization is required when the billed charges are greater than $500.		
L5925	ADD ENDO AK/HIP DISARTIC MNL LOCK	Prior authorization is required when the billed charges are greater than $500.		
L5926	Addition to lower extremity prosthesis, endoskeletal, knee disarticulation, above knee, hip disarticulation, positional rotation unit, any type	Prior authorization is required when the billed charges are greater than $500.		
L5930	ADD ENDO HI ACTV KNEE CNTRL FRAME	Prior authorization is required when the billed charges are greater than $500.		
L5940	ADD ENDOSKEL BELOW KNEE ULTRA-LGHT	Prior authorization is required when the billed charges are greater than $500.		
L5950	ADD ENDOSKEL ABOVE KNEE ULTRA-LGHT	Prior authorization is required when the billed charges are greater than $500.		
L5960	ADD ENDOSKL HIP DISARTC ULTRA-LGHT	Prior authorization is required when the billed charges are greater than $500.		
L5961	ADD ENDO SYS POLYCNTRC HIP JOINT	Prior authorization is required when the billed charges are greater than $500.		
L5962	ADD ENDO BK FLEX PROTVE OUTER COVER	Prior authorization is required when the billed charges are greater than $500.		
L5964	ADD ENDO AK FLXBL PROTVE OUTR COVER	Prior authorization is required when the billed charges are greater than $500.		
L5966	ADD ENDO HIP DISRTC FLX PROTVE COVR	Prior authorization is required when the billed charges are greater than $500.		
L5968	ADD LW LIMB PROSTH MX-AXIAL ANKLE	Prior authorization is required when the billed charges are greater than $500.		
L5969	ADD ENDOSKEL ANKL-FT/ANK PWR ASSIST	Prior authorization is required when the billed charges are greater than $500.		
L5970	ALL LW EXTRM PROSTH FOOT SACH FOOT	Prior authorization is required when the billed charges are greater than $500.		
L5971	ALL LW EXT PROS SACH FOOT REPL ONLY	Prior authorization is required when the billed charges are greater than $500.		
L5972	ALL LOW EXT PROS FOOT FLEXIBLE KEEL	Prior authorization is required when the billed charges are greater than $500.		
L5973	ENDO ANK FOOT MICROPROCSS CNTRL PWR	Prior authorization is required when the billed charges are greater than $500.		
L5974	ALL LW EXTRM PRSTH FT 1 AXIS ANK/FT	Prior authorization is required when the billed charges are greater than $500.		
L5975	ALL LW EXTRM PROSTH COMB 1 AXIS ANK	Prior authorization is required when the billed charges are greater than $500.		
L5976	ALL LW EXTRM PROSTH ENERGY STOR FT	Prior authorization is required when the billed charges are greater than $500.		
L5978	ALL LW EXTRM PRSTH FT MX-AXL ANK/FT	Prior authorization is required when the billed charges are greater than $500.		
L5979	ALL LW XTRM PRSTH MX-AXL ANK 1 PECE	Prior authorization is required when the billed charges are greater than $500.		
L5980	ALL LOW EXTREM PROSTH FLX-FOOT SYS	Prior authorization is required when the billed charges are greater than $500.		
L5981	ALL LOW EXTRM PROSTH FLX-WALK SYS/=	Prior authorization is required when the billed charges are greater than $500.		
L5982	ALL EXOSKEL LW EXT PROS AXIAL ROTAT	Prior authorization is required when the billed charges are greater than $500.		
L5984	ALL ENDOSKEL LW EXT PRSTH AXL ROTAT	Prior authorization is required when the billed charges are greater than $500.		
L5985	ALL ENDOSKL LW XTRM PROSTH DYNAMIC	Prior authorization is required when the billed charges are greater than $500.		
L5986	ALL LW EXTRM PROSTH MX-AXIAL ROT U	Prior authorization is required when the billed charges are greater than $500.		
L5987	ALL LW EXTRM PROSTH SHANK FOOT SYS	Prior authorization is required when the billed charges are greater than $500.		
L5988	ADD LW LMB PRSTH VERTCL SHOCK RDUC	Prior authorization is required when the billed charges are greater than $500.		
L5990	ADD LW EXTRM PROSTH USE ADJ HEEL HT	Prior authorization is required when the billed charges are greater than $500.		
L5991	Addition to lower extremity prostheses, osseointegrated external prosthetic connector	Prior authorization is required when the billed charges are greater than $500.		
L5999	Lower extremity prosthesis, not otherwise specified	Prior authorization is required when the billed charges are greater than $500.		
L6000	PARTIAL HAND THUMB REMAINING	Prior authorization is required when the billed charges are greater than $500.		
L6010	PART HAND LITTLE &/ RING FINGER REM	Prior authorization is required when the billed charges are greater than $500.		
L6020	PARTIAL HAND NO FINGER REMAINING	Prior authorization is required when the billed charges are greater than $500.		
L6026	TRANSCARPL/MC/PART HAND DISART PROS	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1031 Myolectric Upper Extremity Orthoses	
L6050	WRST DSRTC MOLD SOCKET FLEX ELB HNG	Prior authorization is required when the billed charges are greater than $500.		
L6055	WRST DSRTC MOLD SCKT W/XPND INTRFCE	Prior authorization is required when the billed charges are greater than $500.		
L6100	BELW ELB MOLD SOCKT FLXIBLE ELB HNG	Prior authorization is required when the billed charges are greater than $500.		
L6110	BELOW ELBOW MOLDED SOCKET	Prior authorization is required when the billed charges are greater than $500.		
L6120	BELW ELB STEP-UP HINGES HALF CUFF	Prior authorization is required when the billed charges are greater than $500.		
L6130	BELW ELB STMP ACTV LCK HNG 1/2 CUFF	Prior authorization is required when the billed charges are greater than $500.		
L6200	ELB DSRTC MOLD SCKT OTSD LCK FORARM	Prior authorization is required when the billed charges are greater than $500.		
L6205	ELB DSRTC MOLD SCKT XPND INTRFC ARM	Prior authorization is required when the billed charges are greater than $500.		
L6250	ABOVE ELB INTERNAL LOCK ELB FOREARM	Prior authorization is required when the billed charges are greater than $500.		
L6300	SHLDR DISARTC INTRL LOCK ELB FORARM	Prior authorization is required when the billed charges are greater than $500.		
L6310	SHLDR DISART PASS REST COMPL PROSTH	Prior authorization is required when the billed charges are greater than $500.		
L6320	SHLDR DISART PASS REST SHLDR CAP	Prior authorization is required when the billed charges are greater than $500.		
L6350	INTRSCAP THOR INTRL LOCK ELB FORARM	Prior authorization is required when the billed charges are greater than $500.		
L6360	INTERSCAPULAR THOR COMPLT PROSTH	Prior authorization is required when the billed charges are greater than $500.		
L6370	INTERSCAPULAR THOR SHLDR CAP ONLY	Prior authorization is required when the billed charges are greater than $500.		
L6380	IMMED POSTSURG RIGD DRSG WRST DSRTC	Prior authorization is required when the billed charges are greater than $500.		
L6382	IMMED POSTSURG RIGD DRSG ELB DISRTC	Prior authorization is required when the billed charges are greater than $500.		
L6384	IMMED POSTSRG RIGD DRSG SHLDR DSRTC	Prior authorization is required when the billed charges are greater than $500.		
L6386	IMMED POSTSURG EA ADD CAST CHANGE	Prior authorization is required when the billed charges are greater than $500.		
L6388	IMMED POSTSURG RIGID DRSG ONLY	Prior authorization is required when the billed charges are greater than $500.		
L6400	BE MOLD SCKT ENDOSKEL-SFT PROS TISS	Prior authorization is required when the billed charges are greater than $500.		
L6450	ELB DISARTIC MOLD SOCKET ENDOSKEL	Prior authorization is required when the billed charges are greater than $500.		
L6500	ABOVE ELBOW MOLD SOCKET ENDOSKEL	Prior authorization is required when the billed charges are greater than $500.		
L6550	SHLDR DISARTC MOLD SOCKET ENDOSKEL	Prior authorization is required when the billed charges are greater than $500.		
L6570	INTRSCAP THOR MOLD SOCKET ENDOSKEL	Prior authorization is required when the billed charges are greater than $500.		
L6580	PREP WRST DISARTIC PLSTC SOCKT MOLD	Prior authorization is required when the billed charges are greater than $500.		

L6582	PREP WRST DISARTC ELB SCKT DIR FORM	Prior authorization is required when the billed charges are greater than $500.		
L6584	PREP ELB DISARTC PLASTIC SOCKT MOLD	Prior authorization is required when the billed charges are greater than $500.		
L6586	PREP ELB DISARTIC SOCKET DIR FORM	Prior authorization is required when the billed charges are greater than $500.		
L6588	PREP SHLDR DISRTC THOR PLSTC SOCKT	Prior authorization is required when the billed charges are greater than $500.		
L6590	PREP SHLDR DSRTC THOR SCKT DIR FORM	Prior authorization is required when the billed charges are greater than $500.		
L6600	UP EXTREM ADD POLYCNTRC HINGE PAIR	Prior authorization is required when the billed charges are greater than $500.		
L6605	UPPER EXTREM ADD 1 PIVOT HINGE PAIR	Prior authorization is required when the billed charges are greater than $500.		
L6610	UP EXT ADD FLEX METAL HINGE PAIR	Prior authorization is required when the billed charges are greater than $500.		
L6611	ADD UP EXT PROS EXT PWR ADD SWITCH	Prior authorization is required when the billed charges are greater than $500.		
L6615	UP EXTREM ADD DISCNCT LOCK WRST U	Prior authorization is required when the billed charges are greater than $500.		
L6616	UP EXT ADD-DSCNCT INSRT LCK WRST EA	Prior authorization is required when the billed charges are greater than $500.		
L6620	UP EXT ADD FLEX/EXT WRIST UNIT	Prior authorization is required when the billed charges are greater than $500.		
L6621	UP EXTREM PROS ADD FLEX/EXTEN WRIST	Prior authorization is required when the billed charges are greater than $500.		
L6623	UP EXT ADD ROTATL WRST W/LATCH RLSE	Prior authorization is required when the billed charges are greater than $500.		
L6624	UP EXT ADD FLX/EXT ROT WRIST UNIT	Prior authorization is required when the billed charges are greater than $500.		
L6625	UP EXT ADD ROTAT WRST W/CABLE LOCK	Prior authorization is required when the billed charges are greater than $500.		
L6628	UP EXTRM ADD QUICK DISCNCT HOOK	Prior authorization is required when the billed charges are greater than $500.		
L6629	UP EXT ADD QUIK DSCNCT LAMNAT COLLR	Prior authorization is required when the billed charges are greater than $500.		
L6630	UP EXTREM ADD STAINLESS STEEL WRIST	Prior authorization is required when the billed charges are greater than $500.		
L6632	UP EXTREM ADD LATX SUSP SLEEVE EA	Prior authorization is required when the billed charges are greater than $500.		
L6635	UPPER EXTREM ADD LIFT ASSIST ELB	Prior authorization is required when the billed charges are greater than $500.		
L6637	UP EXTREM ADD NUDGE CNTRL ELB LOCK	Prior authorization is required when the billed charges are greater than $500.		
L6638	UP EXT ADD PROS LOCK W/MNL PWR ELB	Prior authorization is required when the billed charges are greater than $500.		
L6640	UP EXTREM ADD SHLDR ABDUCT JNT PAIR	Prior authorization is required when the billed charges are greater than $500.		
L6641	UP EXTRM ADD EXCURSN AMPL PULLEY	Prior authorization is required when the billed charges are greater than $500.		
L6642	UP EXTRM ADD EXCURSN AMPL LEVER	Prior authorization is required when the billed charges are greater than $500.		
L6645	UP EXT ADD SHLDR FLX-ABDUCT JNT EA	Prior authorization is required when the billed charges are greater than $500.		
L6646	UP EXT ADD SHLDR JNT MX PSTN SYS	Prior authorization is required when the billed charges are greater than $500.		
L6647	UP EXT ADD SHLDR LOCK MECH BDY PWR	Prior authorization is required when the billed charges are greater than $500.		
L6648	UP EXT ADD SHLDR LOCK MECH EXT PWR	Prior authorization is required when the billed charges are greater than $500.		
L6650	UP EXTRM ADD SHLDR UNIVERSAL JNT EA	Prior authorization is required when the billed charges are greater than $500.		
L6655	UP EXTREM ADD STD CNTRL CABLE XTRA	Prior authorization is required when the billed charges are greater than $500.		
L6660	UP EXTREM ADD HEVY DUTY CNTRL CABLE	Prior authorization is required when the billed charges are greater than $500.		
L6665	UP EXTREM ADD TEFLON/= CABLE LINING	Prior authorization is required when the billed charges are greater than $500.		
L6670	UP EXTREM ADD HOOK HND CABLE ADAPTR	Prior authorization is required when the billed charges are greater than $500.		
L6672	UP EXT ADD HRNSS CHST/SHLDR SADDLE	Prior authorization is required when the billed charges are greater than $500.		
L6675	UP EXT ADD HARNESS 1 CABLE DESIGN	Prior authorization is required when the billed charges are greater than $500.		
L6676	UP EXT ADD HARNESS 2 CABLE DESIGN	Prior authorization is required when the billed charges are greater than $500.		
L6677	UP EXT ADD HRNSS 3 CNTRL OP DVC&ELB	Prior authorization is required when the billed charges are greater than $500.		
L6680	UP EXTRM ADD TST SCKT WRIST DISARTC	Prior authorization is required when the billed charges are greater than $500.		
L6682	UP EXTRM ADD TST SOCKT ELB DISARTIC	Prior authorization is required when the billed charges are greater than $500.		
L6684	UP EXTRM ADD TST SCKT SHLDR DISARTC	Prior authorization is required when the billed charges are greater than $500.		
L6686	UPPER EXTREM ADDITION SUCTION SOCKT	Prior authorization is required when the billed charges are greater than $500.		
L6687	UP EXT ADD FRME TYPE SCKT BELW ELB	Prior authorization is required when the billed charges are greater than $500.		
L6688	UP EXT ADD FRME TYPE SOCKT ABVE ELB	Prior authorization is required when the billed charges are greater than $500.		
L6689	UP EXT ADD FRAME SCKT SHLDR DISARTC	Prior authorization is required when the billed charges are greater than $500.		
L6690	UP EXT ADD FRAME SCKT INTRSCAP-THOR	Prior authorization is required when the billed charges are greater than $500.		
L6691	UPPER EXTREM ADD REMV INSERT EA	Prior authorization is required when the billed charges are greater than $500.		
L6692	UP EXTREM ADD SILCON GEL INSRT/=EA	Prior authorization is required when the billed charges are greater than $500.		
L6693	UP EXT ADD LOCK ELB FORARM CNTRBAL	Prior authorization is required when the billed charges are greater than $500.		
L6694	ADD UP EXT PROS CSTM W/LOCK MECH	Prior authorization is required when the billed charges are greater than $500.		
L6695	ADD UP EXT PROS CSTM W/O LOCK MECH	Prior authorization is required when the billed charges are greater than $500.		
L6696	ADD UP EXT PROS CNGN/TRAUMAT AMP	Prior authorization is required when the billed charges are greater than $500.		
L6697	ADD UP EXT PROS NOT CNGN/TRAUM AMP	Prior authorization is required when the billed charges are greater than $500.		
L6698	ADD UP EXT PROS LOCK MECH EXC INSRT	Prior authorization is required when the billed charges are greater than $500.		
L6703	TERMINAL DEVICE PASSIVE HAND/MITT	Prior authorization is required when the billed charges are greater than $500.		
L6704	TERMINAL DEVC SPORT/REC/WORK ATTACH	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1031 Myolectric Upper Extremity Orthoses	
L6706	TERMINAL DEVC HOOK MECH VOL OPENING	Prior authorization is required when the billed charges are greater than $500.		
L6707	TERMINAL DEVC HOOK MECH VOL CLOSING	Prior authorization is required when the billed charges are greater than $500.		
L6708	TERMINAL DEVC HAND MECH VOL OPENING	Prior authorization is required when the billed charges are greater than $500.		
L6709	TERMINAL DEVC HAND MECH VOL CLOSING	Prior authorization is required when the billed charges are greater than $500.		
L6711	TERM DVC HOOK MECH VOL OPN PED	Prior authorization is required when the billed charges are greater than $500.		
L6712	TERM DVC HOOK MECH VOL CLOS PED	Prior authorization is required when the billed charges are greater than $500.		
L6713	TERM DVC HAND MECH VOL OPN PED	Prior authorization is required when the billed charges are greater than $500.		
L6714	TERM DEVC HAND MECH VOL CLOS PED	Prior authorization is required when the billed charges are greater than $500.		
L6715	TERM DEVC MX ARTC DIG INIT ISS/REPL	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1031 Myolectric Upper Extremity Orthoses	

L6721	TERM DEVC HOOK/HAND HD MECH VOL OPN	Prior authorization is required when the billed charges are greater than $500.		
L6722	TERM DEVC HOOK/HND HD MECH VOL CLOS	Prior authorization is required when the billed charges are greater than $500.		
L6805	ADD TERM DEVICE MODIFIER WRIST UNIT	Prior authorization is required when the billed charges are greater than $500.		
L6810	ADD TERM DEVC PRECISION PINCH DEVC	Prior authorization is required when the billed charges are greater than $500.		
L6880	ELEC HAND SW/MYOELEC CNTRL ARTC DIG	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1031 Myolectric Upper Extremity Orthoses	
L6881	AUTO GRASP ADD UPPER LIMB PROS DEVC	Prior authorization is required when the billed charges are greater than $500.		
L6882	MICRPROCSS CNTRL ADD UP LIMB PROSTH	Prior authorization is required when the billed charges are greater than $500.		
L6883	REPL SOCKET BE/WD MOLDED TO PT MDL	Prior authorization is required when the billed charges are greater than $500.		
L6884	REPL SOCKT ABOVE ELB DISART MOLD PT	Prior authorization is required when the billed charges are greater than $500.		
L6885	REPL SOCKT SD/INTRSCAP THOR MOLD PT	Prior authorization is required when the billed charges are greater than $500.		
L6890	ADD UP EXT PROSTH GLOV TERM PRFAB	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1031 Myolectric Upper Extremity Orthoses	
L6895	ADD UP EXT PROSTH GLOV TERM CSTM	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1031 Myolectric Upper Extremity Orthoses	
L6900	HND REST PART W/GLOV THUMB/1 FNGR	Prior authorization is required when the billed charges are greater than $500.		
L6905	HND REST PART HND W/GLOV MX FNGR	Prior authorization is required when the billed charges are greater than $500.		
L6910	HND REST PART HND W/GLOV NO FNGR	Prior authorization is required when the billed charges are greater than $500.		
L6915	HAND REST REPL GLOVE FOR ABOVE	Prior authorization is required when the billed charges are greater than $500.		
L6920	WRST DISARTC OTTO BOCK/=SWTCH CNTRL	Prior authorization is required when the billed charges are greater than $500.		
L6925	WRIST DSRTC OTTO BOCK/=MYOELC CNTRL	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1031 Myolectric Upper Extremity Orthoses	
L6930	BELW ELBOW OTTO BOCK/=SWITCH CNTRL	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1031 Myolectric Upper Extremity Orthoses	
L6935	BELW ELBOW OTTO BOCK/=MYOELEC CNTRL	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1031 Myolectric Upper Extremity Orthoses	
L6940	ELB DISRTC OTTO BOCK/=SWITCH CNTRL	Prior authorization is required when the billed charges are greater than $500.		
L6945	ELB DISRTC OTTO BOCK/=MYOELC CNTRL	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1031 Myolectric Upper Extremity Orthoses	
L6950	ABOVE ELB OTTO BOCK/=SWITCH CONTROL	Prior authorization is required when the billed charges are greater than $500.		
L6955	ABVE ELBOW OTTO BOCK/=MYOELEC CNTRL	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1031 Myolectric Upper Extremity Orthoses	
L6960	SHLDR DSRTC OTTO BOCK/=SWTCH CNTRL	Prior authorization is required when the billed charges are greater than $500.		
L6965	SHLDR DSRTC OTTO BOCK/=MYOELC CNTRL	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1031 Myolectric Upper Extremity Orthoses	
L6970	INTERSCAPULR-THOR OTTO BOCK/=SWITCH	Prior authorization is required when the billed charges are greater than $500.		
L6975	INTERSCAP-THORAC OTTO BOCK/=MYOELEC	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1031 Myolectric Upper Extremity Orthoses	
L7007	ELEC HND SWTCH/MYOELEC CNTRL ADULT	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1031 Myolectric Upper Extremity Orthoses	
L7008	ELEC HAND SWITCH/MYOELEC CNTRL PED	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1031 Myolectric Upper Extremity Orthoses	
L7009	ELEC HOOK SWITCH/MYOELC CNTRL ADULT	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1031 Myolectric Upper Extremity Orthoses	
L7040	PREHENSILE ACTUATOR SWITCH CONTROL	Prior authorization is required when the billed charges are greater than $500.		
L7045	ELEC HOOK SWITCH MYOELEC CONTRL PED	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1031 Myolectric Upper Extremity Orthoses	
L7170	ELEC ELB HOSMER/EQUAL SWITCH CNTRL	Prior authorization is required when the billed charges are greater than $500.		
L7180	ELEC ELB SEQENTL CNTRL ELB&TRM DEV	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1031 Myolectric Upper Extremity Orthoses	
L7181	ELEC ELB SIMULTAN CNTRL ELB&TRM DEV	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1031 Myolectric Upper Extremity Orthoses	
L7185	ELEC ELB ADOLES VRITY VILL/=SWITCH	Prior authorization is required when the billed charges are greater than $500.		
L7186	ELEC ELB CHLD VRITY VILL/=SWITCH	Prior authorization is required when the billed charges are greater than $500.		
L7190	ELEC ELB ADOLES VRITY VILL/=MYOELC	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1031 Myolectric Upper Extremity Orthoses	
L7191	ELEC ELB CHLD VRITY VILL/=MYOELEC	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1031 Myolectric Upper Extremity Orthoses	
L7259	ELECTRONIC WRIST ROTATOR ANY TYPE	Prior authorization is required when the billed charges are greater than $500.		
L7360	SIX VOLT BATTERY EACH	Prior authorization is required when the billed charges are greater than $500.		
L7362	BATTERY CHARGER SIX VOLT EACH	Prior authorization is required when the billed charges are greater than $500.		
L7364	TWELVE VOLT BATTERY EACH	Prior authorization is required when the billed charges are greater than $500.		
L7366	BATTERY CHARGER 12 VOLT EACH	Prior authorization is required when the billed charges are greater than $500.		
L7367	LITHIUM ION BATT RECHARGEABLE REPL	Prior authorization is required when the billed charges are greater than $500.		
L7368	LITHIUM ION BATT CHARGER REPL ONLY	Prior authorization is required when the billed charges are greater than $500.		
L7400	ADD UP EXT PROS BE/WD ULTRALT MATL	Prior authorization is required when the billed charges are greater than $500.		
L7401	ADD UP EXT PROS ABV ED ULTRALT MATL	Prior authorization is required when the billed charges are greater than $500.		
L7402	ADD UP EXT PROS SD/INTRSCAP THOR	Prior authorization is required when the billed charges are greater than $500.		
L7403	ADD UP EXT PROS BE/WD ACRYLIC MATL	Prior authorization is required when the billed charges are greater than $500.		

L7404	ADD UP EXT PROS ABVE ED ACRYLC MATL	Prior authorization is required when the billed charges are greater than $500.		
L7405	ADD UP EXT PROS SD/INTERSCAP THOR	Prior authorization is required when the billed charges are greater than $500.		
L7499	Upper extremity prosthesis, not otherwise specified	Prior authorization is required for billed charges greater than $500.		
L7510	Prosthetic repair	Prior authorization is required for billed charges greater than $500.		
L7520	REPR PROSTH DEVC LABR CMPNT-15 MIN	Prior authorization is required when the billed charges are greater than $500.		
L7600	PROSETIC DONNING SLEEVE MATERIAL EA	Prior authorization is required when the billed charges are greater than $500.		
L7700	GKT/SEAL USE PROS SOC INS ANY TY EA	Prior authorization is required when the billed charges are greater than $500.		
L7900	MALE VACUUM ERECTION SYSTEM	Prior authorization is required when the billed charges are greater than $500.		
L7902	TENSION RING VAC ERECT DEVC REPL EA	Prior authorization is required when the billed charges are greater than $500.		
L8000	Breast prosthesis, mastectomy bra, without integrated breast prosthesis form, any size, any type	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1027 Breast Reconstructive Surgery	
L8001	Breast prosthesis, mastectomy bra, with integrated breast prosthesis form, unilateral, any size, any type	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1027 Breast Reconstructive Surgery	
L8002	Breast prosthesis, mastectomy bra, with integrated breast prosthesis form, bilateral, any size, any type	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1027 Breast Reconstructive Surgery	
L8010	Breast prosthesis, mastectomy sleeve	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1027 Breast Reconstructive Surgery	
L8015	External breast prosthesis garment, with mastectomy form, post mastectomy	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1027 Breast Reconstructive Surgery	
L8020	Breast prosthesis, mastectomy form	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1027 Breast Reconstructive Surgery	
L8030	Breast prosthesis, silicone or equal, without integral adhesive	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1027 Breast Reconstructive Surgery	
L8031	Breast prosthesis, silicone or equal, with integral adhesive	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1027 Breast Reconstructive Surgery	
L8032	Nipple prosthesis, prefabricated, reusable, any type, each	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1027 Breast Reconstructive Surgery	
L8033	NIP PRS CSTM FB RUSABL ANY MTL T EA	Prior authorization is required when the billed charges are greater than $500.		
L8035	Custom breast prosthesis, post mastectomy, molded to patient model	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1027 Breast Reconstructive Surgery	
L8039	Breast prosthesis, not otherwise specified	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1027 Breast Reconstructive Surgery	
L8040	NASL PROSTH PROVIDED NON-PHYSICIAN	Prior authorization is required when the billed charges are greater than $500.		
L8041	MIDFCE PROSTH PROV NON-PHYSICIAN	Prior authorization is required when the billed charges are greater than $500.		
L8042	ORB PROSTH PROVIDED NON-PHYSICIAN	Prior authorization is required when the billed charges are greater than $500.		
L8043	UPPER FCE PROSTH PROV NON-PHYSICIAN	Prior authorization is required when the billed charges are greater than $500.		
L8044	HEMI-FCE PROSTH PROV NON-PHYSICIAN	Prior authorization is required when the billed charges are greater than $500.		
L8045	AURICULAR PROSTH PROV NON-PHYSICIAN	Prior authorization is required when the billed charges are greater than $500.		
L8046	PART FCE PROSTH PROV NON-PHYSICIAN	Prior authorization is required when the billed charges are greater than $500.		
L8047	NASL SEPTAL PROSTH PROV NON-PHYS	Prior authorization is required when the billed charges are greater than $500.		
L8048	Unspecified maxillofacial prosthesis, by report, provided by a non-physician	Prior authorization is required for billed charges greater than $500.		
L8049	REP MAXLOFCE PROS EA 15 MIN NON-MD	Prior authorization is required when the billed charges are greater than $500.		
L8300	TRUSS SINGLE WITH STANDARD PAD	Prior authorization is required when the billed charges are greater than $500.		
L8310	TRUSS DOUBLE WITH STANDARD PADS	Prior authorization is required when the billed charges are greater than $500.		
L8320	TRUSS ADDITION STANDARD PAD H2O PAD	Prior authorization is required when the billed charges are greater than $500.		
L8330	TRUSS ADD STANDARD PAD SCROTAL PAD	Prior authorization is required when the billed charges are greater than $500.		
L8400	PROSTHETIC SHEATH BELOW KNEE EACH	Prior authorization is required when the billed charges are greater than $500.		
L8410	PROSTHETIC SHEATH ABOVE KNEE EACH	Prior authorization is required when the billed charges are greater than $500.		
L8415	PROSTHETIC SHEATH UPPER LIMB EACH	Prior authorization is required when the billed charges are greater than $500.		
L8417	PROS SHEATH/SOCK-GEL CUSHN BK/AK EA	Prior authorization is required when the billed charges are greater than $500.		
L8420	PROSTHETIC SOCK MX PLY BELW KNEE EA	Prior authorization is required when the billed charges are greater than $500.		
L8430	PROSTHETIC SOCK MX PLY ABVE KNEE EA	Prior authorization is required when the billed charges are greater than $500.		
L8435	PROSTH SOCK MX PLY UPPER LIMB EA	Prior authorization is required when the billed charges are greater than $500.		
L8440	PROSTHETIC SHRINKER BELOW KNEE EACH	Prior authorization is required when the billed charges are greater than $500.		
L8460	PROSTHETIC SHRINKER ABOVE KNEE EACH	Prior authorization is required when the billed charges are greater than $500.		
L8465	PROSTHETIC SHRINKER UPPER LIMB EACH	Prior authorization is required when the billed charges are greater than $500.		
L8470	PROSTH SOCK SINGLE PLY FIT BK EACH	Prior authorization is required when the billed charges are greater than $500.		
L8480	PROSTH SOCK 1 PLY FIT ABOVE KNEE EA	Prior authorization is required when the billed charges are greater than $500.		
L8485	PROSTH SOCK 1 PLY FIT UPPER LIMB EA	Prior authorization is required when the billed charges are greater than $500.		
L8499	Unlisted procedure for miscellaneous prosthetic services	Prior authorization is required for billed charges greater than $500.		
L8500	ARTIFICIAL LARYNX ANY TYPE	Prior authorization is required when the billed charges are greater than $500.		
L8501	TRACHEOSTOMY SPEAKING VALVE	Prior authorization is required when the billed charges are greater than $500.		
L8505	ARTFICL LARYNX REPLCMT BATTRY/ACSS	Prior authorization is required when the billed charges are greater than $500.		
L8507	TRACHEO-ESOPH VOICE PROSTH PT INSRT	Prior authorization is required when the billed charges are greater than $500.		
L8509	TRACHEO-ESOPH VOICE PROS INSRT PROV	Prior authorization is required when the billed charges are greater than $500.		
L8510	VOICE AMPLIFIER	Prior authorization is required when the billed charges are greater than $500.		
L8511	INSRT INDWLL TRACHEOESOPH PROS W/WO	Prior authorization is required when the billed charges are greater than $500.		
L8512	GELATIN CAPS/EQUVALNT W/TRACHEOESOP	Prior authorization is required when the billed charges are greater than $500.		
L8513	CLEANING DEVC USED W/TRACHEOESOPH V	Prior authorization is required when the billed charges are greater than $500.		

L8514	TRACHEOESOPH PUNCT DILAT REPLCMT ON	Prior authorization is required when the billed charges are greater than $500.		
L8515	GELATN CAP APPLC DEV TE VOICE PRSTH	Prior authorization is required when the billed charges are greater than $500.		
L8600	Implantable breast prosthesis, silicone or equal	Cosmetic procedures are a non-covered service. Prior authorization is required for billed charges greater than $500, medical necessity criteria must be met.		
L8603	INJ COLL IMPL URIN TRACT 2.5 ML SYR	Prior authorization is required when the billed charges are greater than $500.		
L8604	INJ BULKING AGT URINARY TRACT 1 ML	Prior authorization is required when the billed charges are greater than $500.		
L8605	INJ BLK AGT DX/HA CP IMPL ANAL 1 ML	Prior authorization is required when the billed charges are greater than $500.		
L8606	INJ SYNTH IMPL URIN TRACT 1 ML SYR	Prior authorization is required when the billed charges are greater than $500.		
L8607	INJ BLK AGT VC MEDIALIZATION 0.1 ML	Prior authorization is required when the billed charges are greater than $500.		
L8608	Miscellaneous external component, supply or accessory for use with the argus ii retinal prosthesis system	Prior authorization is required for billed charges greater than $500.		
L8609	Artificial cornea	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1221 Corneal Transplantation	
L8610	OCULAR IMPLANT	Prior authorization is required when the billed charges are greater than $500.		
L8612	AQUEOUS SHUNT	Prior authorization is required when the billed charges are greater than $500.		
L8613	OSSICULA IMPLANT	Prior authorization is required when the billed charges are greater than $500.		
L8614	COCHLEAR DEVC INCL INT&EXT COMPNENT	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1145 Cochlear Implants	
L8615	Headset/headpiece for use with cochlear implant device, replacement	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1145 Cochlear Implants	
L8616	Microphone for use with cochlear implant device, replacement	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1145 Cochlear Implants	
L8617	Transmitting coil for use with cochlear implant device, replacement	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1145 Cochlear Implants	
L8618	Transmitter cable for use with cochlear implant device or auditory osseointegrated device, replacement	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1145 Cochlear Implants	
L8619	Cochlear implant, external speech processor and controller, integrated system, replacement	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1145 Cochlear Implants	
L8621	Zinc air battery for use with cochlear implant device and auditory osseointegrated sound processors, replacement, each	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1145 Cochlear Implants	
L8622	Alkaline battery for use with cochlear implant device, any size, replacement, each	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1145 Cochlear Implants	
L8623	Lithium ion battery for use with cochlear implant device speech processor, other than ear level, replacement, each	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1145 Cochlear Implants	
L8624	Lithium ion battery for use with cochlear implant or auditory osseointegrated device speech processor, ear level, replacement, each	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1145 Cochlear Implants	
L8625	External recharging system for battery for use with cochlear implant or auditory osseointegrated device, replacement only, each	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1145 Cochlear Implants	
L8627	Cochlear implant, external speech processor, component, replacement	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1145 Cochlear Implants	
L8628	Cochlear implant, external controller component, replacement	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1145 Cochlear Implants	
L8629	Transmitting coil and cable, integrated, for use with cochlear implant device, replacement	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1145 Cochlear Implants	
L8630	METACARPOPHALANGEAL JOINT IMPLANT	Prior authorization is required when the billed charges are greater than $500.		
L8631	MPJ REPLCMT TWO/MORE PECES METL CER	Prior authorization is required when the billed charges are greater than $500.		
L8641	METATARSAL JOINT IMPLANT	Prior authorization is required when the billed charges are greater than $500.		
L8642	HALLUX IMPLANT	Prior authorization is required when the billed charges are greater than $500.		
L8658	IP JOINT SPACER SILICONE/= EA	Prior authorization is required when the billed charges are greater than $500.		
L8659	IP FNGR JNT REPL TWO/> PECES METAL	Prior authorization is required when the billed charges are greater than $500.		
L8670	VASC GRAFT MATERIAL SYNTH IMPLANT	Prior authorization is required when the billed charges are greater than $500.		
L8678	Electrical stimulator supplies (external) for use with implantable neurostimulator, per month	Prior authorization is required when the billed charges are greater than $500.		
L8679	IMPL NEUROSTIMULATOR PULSE GEN ANY	Prior authorization is required.		
L8680	IMPL NEUROSTIMULATOR ELECTRODE EA	Prior authorization is required.		
L8681	Patient programmer (external) for use with implantable programmable neurostimulator pulse generator, replacement only	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1009 Deep Brain Stimulation	
L8682	IMPL NEUROSTIMULATOR RADIOFREQ RECV	Prior authorization is required when the billed charges are greater than $500.		
L8683	Radiofrequency transmitter (external) for use with implantable neurostimulator radiofrequency receiver	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1009 Deep Brain Stimulation	
L8684	Radiofrequency transmitter (external) for use with implantable sacral root neurostimulator receiver for bowel and bladder management, replacement	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1009 Deep Brain Stimulation	
L8685	IMPL NEUROSTIM 1 ARRAY RECHARGEABLE	Prior authorization is required when the billed charges are greater than $500.		
L8686	IMPL NEUROSTIM 1 ARRAY NON-RECHARGE	Prior authorization is required when the billed charges are greater than $500.		
L8687	IMPL NEUROSTIM 2 ARRAY RECHARGEABLE	Prior authorization is required when the billed charges are greater than $500.		
L8688	IMPL NEUROSTIM 2 ARRAY NON-RECHARGE	Prior authorization is required when the billed charges are greater than $500.		
L8689	External recharging system for battery (internal) for use with implantable neurostimulator, replacement only	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1009 Deep Brain Stimulation	
L8690	AUDITORY OSSEOINTEGRTD INT/EXT COMP	Prior authorization is required when the billed charges are greater than $500.		

L8691	AO D EXT SP EXCL TRNDCR/ACTR RPL EA	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1190 External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing	
L8692	AUDITORY OSSEOINTEGRAT DEV BDY WORN	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1190 External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing	
L8693	AUD OSSEOINTEGRATED DEVC ABUT REPL	Prior authorization is required when the billed charges are greater than $500.		
L8694	AUD OI DVC TRNSDUCR/ACTUATR REPL EA	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1190 External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing	
L8695	External recharging system for battery (external) for use with implantable neurostimulator, replacement only	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1009 Deep Brain Stimulation	
L8696	ANT FOR IMPL DIA/PN ST DEV REPL EA	Prior authorization is required when the billed charges are greater than $500.		
L8698	Miscellaneous component, supply or accessory for use with total artificial heart system	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1104 Artificial Hearts and Ventricular Assist Devices	
L8699	Prosthetic implant, not otherwise specified	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1145 Cochlear Implants	
L9900	ORTHO/PROSTH SUPP ACCES &/ SERV	Prior authorization is required when the billed charges are greater than $500.		
No specific codes listed		Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1205 Testing for Genetic Disease	
P9020	Platelet rich plasma, each unit	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1132 Skin Replacement Therapy For Chronic Non healing Wounds in The Outpatient Setting	
P9022	Red blood cells, washed, each unit	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1132 Skin Replacement Therapy For Chronic Non healing Wounds in The Outpatient Setting	
Q0138	Injection, ferumoxytol, for treatment of iron deficiency anemia, 1 mg (**non-esrd use**)	Prior authorization is required.		
Q0181	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	Prior authorization is required.		
Q0477	PWR MODULE PT CABL ELEC/PN VAD REPL	Prior authorization is required when the billed charges are greater than $500.		
Q0478	PWR ADAPTR ELEC/PNEUMAT VAD VEH TYP	Prior authorization is required when the billed charges are greater than $500.		
Q0479	POWER MODULE ELEC/PNEUMAT VAD REPL	Prior authorization is required when the billed charges are greater than $500.		
Q0480	DRIVER FOR PNEUMATIC VAD REPL ONLY	Prior authorization is required when the billed charges are greater than $500.		
Q0481	MICRPROCSS CU FOR ELEC VAD REPL	Prior authorization is required when the billed charges are greater than $500.		
Q0482	MICRPROCSS CU ELEC/PNEUMAT VAD REPL	Prior authorization is required when the billed charges are greater than $500.		
Q0483	MON/DISPLAY MODULE W/ELEC VAD REPL	Prior authorization is required when the billed charges are greater than $500.		
Q0484	MON ELEC OR ELEC/PNEUMAT VAD REPL	Prior authorization is required when the billed charges are greater than $500.		
Q0485	MON CNTRL CABLE FOR ELEC VAD REPL	Prior authorization is required when the billed charges are greater than $500.		
Q0486	MON CABLE FOR ELEC/PNEUMAT VAD RE	Prior authorization is required when the billed charges are greater than $500.		
Q0487	LEADS FOR ANY ELEC/PNEUMAT VAD REPL	Prior authorization is required when the billed charges are greater than $500.		
Q0488	POWER PACK BASE FOR ELEC VAD REPL	Prior authorization is required when the billed charges are greater than $500.		
Q0489	PWR PACK BASE ELEC/PNEUMAT VAD RE	Prior authorization is required when the billed charges are greater than $500.		
Q0490	EMERGENCY PWR SRC FOR ELEC VAD RE	Prior authorization is required when the billed charges are greater than $500.		
Q0491	EMERG PWR SRC ELEC/PNEUMAT VAD RE	Prior authorization is required when the billed charges are greater than $500.		
Q0492	EMERG PWR CABLE FOR ELEC VAD REPL	Prior authorization is required when the billed charges are greater than $500.		
Q0493	EMRG PWR CABL ELEC/PNEUMAT VAD REPL	Prior authorization is required when the billed charges are greater than $500.		
Q0494	EMERGENCY HAND PUMP REPLACEMNT ONL	Prior authorization is required when the billed charges are greater than $500.		
Q0495	BATT CHRG ELEC/ELEC-PNEUMAT VAD RPL	Prior authorization is required when the billed charges are greater than $500.		
Q0496	BATT NOT LITHIUM-ION ELEC VAD REPL	Prior authorization is required when the billed charges are greater than $500.		
Q0497	BATT CLPS ELEC/ELEC-PNEUMAT VAD RPL	Prior authorization is required when the billed charges are greater than $500.		
Q0498	HOLSTR ELEC/ELEC-PNEUMAT VAD REPL	Prior authorization is required when the billed charges are greater than $500.		
Q0499	BELT/VEST/BAG ANY TYPE VAD RPL ONLY	Prior authorization is required when the billed charges are greater than $500.		
Q0500	FLTRS ELEC OR ELEC/PNEUMAT VAD REPL	Prior authorization is required when the billed charges are greater than $500.		
Q0501	SHOWR COVR ELEC/ELEC-PNEUMT VAD RPL	Prior authorization is required when the billed charges are greater than $500.		
Q0502	MOBILITY CART FOR PNEUMAT VAD REPL	Prior authorization is required when the billed charges are greater than $500.		
Q0503	BATT FOR PNEUMAT VAD REPL ONLY EA	Prior authorization is required when the billed charges are greater than $500.		
Q0504	PWR ADPTR PNEUMAT VAD REPL VEH TYPE	Prior authorization is required when the billed charges are greater than $500.		
Q0506	BATT LITHIUM-ION ELEC VAD REPL	Prior authorization is required when the billed charges are greater than $500.		
Q0507	Miscellaneous supply or accessory for use with an external ventricular assist device	Prior authorization is required for billed charges greater than $500.		
Q0508	Miscellaneous supply or accessory for use with an implanted ventricular assist device	Prior authorization is required for billed charges greater than $500.		
Q0509	Miscellaneous supply or accessory for use with any implanted ventricular assist device for which payment was not made under medicare part a	Prior authorization is required for billed charges greater than $500.		
Q4001	CAST BDY CAST ADLT W/WO HEAD PLAST	Prior authorization is required when the billed charges are greater than $500.		
Q4002	CAST BDY CAST ADLT W/WO HEAD F-GLSS	Prior authorization is required when the billed charges are greater than $500.		
Q4003	CAST SPL SHLDR CAST ADULT PLASTR	Prior authorization is required when the billed charges are greater than $500.		
Q4004	CAST SPL SHLDR CAST ADULT FIBRGLS	Prior authorization is required when the billed charges are greater than $500.		
Q4005	CAST SPL LONG ARM CAST ADULT PLASTR	Prior authorization is required when the billed charges are greater than $500.		
Q4006	CAST SPL LONG ARM CAST ADLT FIBRGLS	Prior authorization is required when the billed charges are greater than $500.		
Q4007	CAST SPL LNG ARM CAST PED PLASTR	Prior authorization is required when the billed charges are greater than $500.		
Q4008	CAST SPL LNG ARM CAST PED FIBRGLS	Prior authorization is required when the billed charges are greater than $500.		
Q4009	CAST SPL SHORT ARM CAST ADLT PLASTR	Prior authorization is required when the billed charges are greater than $500.		

Q4010	CAST SPL SHRT ARM CAST ADLT FIBRGLS	Prior authorization is required when the billed charges are greater than $500.		
Q4011	CAST SPL SHORT ARM CAST PED PLASTR	Prior authorization is required when the billed charges are greater than $500.		
Q4012	CAST SPL SHORT ARM CAST PED FIBRGLS	Prior authorization is required when the billed charges are greater than $500.		
Q4013	CAST SPL GAUNTLT CAST ADULT PLASTR	Prior authorization is required when the billed charges are greater than $500.		
Q4014	CAST SPL GAUNTLET CAST ADLT F-GLASS	Prior authorization is required when the billed charges are greater than $500.		
Q4015	CAST SPL GAUNTLT CAST PED PLASTR	Prior authorization is required when the billed charges are greater than $500.		
Q4016	CAST SPL GAUNTLET CAST PED F-GLASS	Prior authorization is required when the billed charges are greater than $500.		
Q4017	CAST SPL LNG ARM SPLINT ADLT PLASTR	Prior authorization is required when the billed charges are greater than $500.		
Q4018	CAST SPL LNG ARM SPLNT ADLT FIBRGLS	Prior authorization is required when the billed charges are greater than $500.		
Q4019	CAST SPL LNG ARM SPLINT PED PLASTR	Prior authorization is required when the billed charges are greater than $500.		
Q4020	CAST SPL LNG ARM SPLINT PED FIBRGLS	Prior authorization is required when the billed charges are greater than $500.		
Q4021	CAST SPL SHRT ARM SPLINT ADLT PLAST	Prior authorization is required when the billed charges are greater than $500.		
Q4022	CAST SPL SHRT ARM SPLNT ADLT F-GLSS	Prior authorization is required when the billed charges are greater than $500.		
Q4023	CAST SPL SHORT ARM SPLINT PED PLAST	Prior authorization is required when the billed charges are greater than $500.		
Q4024	CAST SPL SHRT ARM SPLNT PED FIBRGLS	Prior authorization is required when the billed charges are greater than $500.		
Q4025	CAST SPL HIP SPICA ADULT PLASTR	Prior authorization is required when the billed charges are greater than $500.		
Q4026	CAST SPL HIP SPICA ADULT FIBRGLS	Prior authorization is required when the billed charges are greater than $500.		
Q4027	CAST SPL HIP SPICA PEDIATRIC PLASTR	Prior authorization is required when the billed charges are greater than $500.		
Q4028	CAST SPL HIP SPICA PED FIBRGLS	Prior authorization is required when the billed charges are greater than $500.		
Q4029	CAST SPL LONG LEG CAST ADULT PLASTR	Prior authorization is required when the billed charges are greater than $500.		
Q4030	CAST SPL LONG LEG CAST ADLT FIBRGLS	Prior authorization is required when the billed charges are greater than $500.		
Q4031	CAST SPL LNG LEG CAST PED PLASTR	Prior authorization is required when the billed charges are greater than $500.		
Q4032	CAST SPL LNG LEG CAST PED FIBRGLS	Prior authorization is required when the billed charges are greater than $500.		
Q4033	CAST LNG LEG CYCLE CAST ADLT PLAST	Prior authorization is required when the billed charges are greater than $500.		
Q4034	CAST LNG LEG CYCLE CAST ADLT F-GLSS	Prior authorization is required when the billed charges are greater than $500.		
Q4035	CAST LNG LEG CYCLE CAST PED PLAST	Prior authorization is required when the billed charges are greater than $500.		
Q4036	CAST LNG LEG CYCLE CAST PED F-GLSS	Prior authorization is required when the billed charges are greater than $500.		
Q4037	CAST SPL SHORT LEG CAST ADLT PLASTR	Prior authorization is required when the billed charges are greater than $500.		
Q4038	CAST SPL SHRT LEG CAST ADLT FIBRGLS	Prior authorization is required when the billed charges are greater than $500.		
Q4039	CAST SPL SHORT LEG CAST PED PLASTR	Prior authorization is required when the billed charges are greater than $500.		
Q4040	CAST SPL SHORT LEG CAST PED FIBRGLS	Prior authorization is required when the billed charges are greater than $500.		
Q4041	CAST SPL LNG LEG SPLINT ADLT PLASTR	Prior authorization is required when the billed charges are greater than $500.		
Q4042	CAST SPL LNG LEG SPLNT ADLT FIBRGLS	Prior authorization is required when the billed charges are greater than $500.		
Q4043	CAST SPL LNG LEG SPLINT PED PLASTR	Prior authorization is required when the billed charges are greater than $500.		
Q4044	CAST SPL LNG LEG SPLINT PED FIBRGLS	Prior authorization is required when the billed charges are greater than $500.		
Q4045	CAST SPL SHRT LEG SPLINT ADLT PLAST	Prior authorization is required when the billed charges are greater than $500.		
Q4046	CAST SPL SHRT LEG SPLNT ADLT F-GLSS	Prior authorization is required when the billed charges are greater than $500.		
Q4047	CAST SPL SHORT LEG SPLINT PED PLAST	Prior authorization is required when the billed charges are greater than $500.		
Q4048	CAST SPL SHRT LEG SPLNT PED FIBRGLS	Prior authorization is required when the billed charges are greater than $500.		
Q4049	FINGER SPLINT STATIC	Prior authorization is required when the billed charges are greater than $500.		
Q4050	Cast supplies, for unlisted types and materials of casts	Prior authorization is required for billed charges greater than $500.		
Q4051	Splint supplies, miscellaneous (includes thermoplastics, strapping, fasteners, padding and other supplies)	Prior authorization is required for billed charges greater than $500.		
Q4081	Injection, epoetin alfa, 100 units (**for esrd on dialysis**)	Prior authorization is required.		
Q4100	Skin substitute, not otherwise specified	Prior authorization is required.		
Q4110	PriMatrix, per sq cm	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1132 Skin Replacement Therapy For Chronic Non healing Wounds in The Outpatient Setting	
Q4111	GammaGraft, per sq cm	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1132 Skin Replacement Therapy For Chronic Non healing Wounds in The Outpatient Setting	
Q4112	Cymetra, injectable, 1 cc	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1132 Skin Replacement Therapy For Chronic Non healing Wounds in The Outpatient Setting	
Q4113	GRAFTJACKET XPRESS, injectable, 1 cc	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1132 Skin Replacement Therapy For Chronic Non healing Wounds in The Outpatient Setting	
Q4115	AlloSkin, per sq cm	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1132 Skin Replacement Therapy For Chronic Non healing Wounds in The Outpatient Setting	
Q4117	HYALOMATRIX, per sq cm	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1132 Skin Replacement Therapy For Chronic Non healing Wounds in The Outpatient Setting	
Q4118	MatriStem micromatrix, 1 mg	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1132 Skin Replacement Therapy For Chronic Non healing Wounds in The Outpatient Setting	
Q4122	DermACELL, DermACELL AWM or DermACELL AWM Porous, per sq cm	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1132 Skin Replacement Therapy For Chronic Non healing Wounds in The Outpatient Setting	
Q4123	AlloSkin RT, per sq cm	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1132 Skin Replacement Therapy For Chronic Non healing Wounds in The Outpatient Setting	
Q4124	OASIS ultra tri-layer wound matrix, per sq cm	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1132 Skin Replacement Therapy For Chronic Non healing Wounds in The Outpatient Setting	
Q4125	ArthroFlex, per sq cm	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1132 Skin Replacement Therapy For Chronic Non healing Wounds in The Outpatient Setting	

Q4126	MemoDerm, DermaSpan, TranZgraft or IntéguPly, per sq cm	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1132 Skin Replacement Therapy For Chronic Non healing Wounds in The Outpatient Setting	
Q4127	Talymed, per sq cm	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1132 Skin Replacement Therapy For Chronic Non healing Wounds in The Outpatient Setting	
Q4134	HMatrix, per sq cm	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1132 Skin Replacement Therapy For Chronic Non healing Wounds in The Outpatient Setting	
Q4135	Mediskin, per sq cm	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1132 Skin Replacement Therapy For Chronic Non healing Wounds in The Outpatient Setting	
Q4136	E-Z Derm, per sq cm	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1132 Skin Replacement Therapy For Chronic Non healing Wounds in The Outpatient Setting	
Q4137	AmnioExcel, AmnioExcel Plus or BioDExcel, per sq cm	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1132 Skin Replacement Therapy For Chronic Non healing Wounds in The Outpatient Setting	
Q4138	BioDFence DryFlex, per sq cm	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1132 Skin Replacement Therapy For Chronic Non healing Wounds in The Outpatient Setting	
Q4139	AmnioMatrix or BioDMatrix, injectable, 1 cc	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1132 Skin Replacement Therapy For Chronic Non healing Wounds in The Outpatient Setting	
Q4140	BioDFence, per sq cm	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1132 Skin Replacement Therapy For Chronic Non healing Wounds in The Outpatient Setting	
Q4141	AlloSkin AC, per sq cm	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1132 Skin Replacement Therapy For Chronic Non healing Wounds in The Outpatient Setting	
Q4142	XCM biologic tissue matrix, per sq cm	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1132 Skin Replacement Therapy For Chronic Non healing Wounds in The Outpatient Setting	
Q4143	Repriza, per sq cm	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1132 Skin Replacement Therapy For Chronic Non healing Wounds in The Outpatient Setting	
Q4145	EpiFix, injectable, 1 mg	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1132 Skin Replacement Therapy For Chronic Non healing Wounds in The Outpatient Setting	
Q4146	Tensix, per sq cm	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1132 Skin Replacement Therapy For Chronic Non healing Wounds in The Outpatient Setting	
Q4147	Architect, Architect PX, or Architect FX, extracellular matrix, per sq cm	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1132 Skin Replacement Therapy For Chronic Non healing Wounds in The Outpatient Setting	
Q4148	Neox Cord 1K, Neox Cord RT, or Clarix Cord 1K, per sq cm	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1132 Skin Replacement Therapy For Chronic Non healing Wounds in The Outpatient Setting	
Q4149	Excellagen, 0.1 cc	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1132 Skin Replacement Therapy For Chronic Non healing Wounds in The Outpatient Setting	
Q4150	AlloWrap DS or dry, per sq cm	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1132 Skin Replacement Therapy For Chronic Non healing Wounds in The Outpatient Setting	
Q4151	AmnioBand or Guardian, per sq cm	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1132 Skin Replacement Therapy For Chronic Non healing Wounds in The Outpatient Setting	
Q4153	Dermavest and Plurivest, per sq cm	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1132 Skin Replacement Therapy For Chronic Non healing Wounds in The Outpatient Setting	
Q4155	Neox Flo or Clarix Flo 1 mg	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1132 Skin Replacement Therapy For Chronic Non healing Wounds in The Outpatient Setting	
Q4156	Neox 100 or Clarix 100, per sq cm	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1132 Skin Replacement Therapy For Chronic Non healing Wounds in The Outpatient Setting	
Q4157	Revitalon, per sq cm	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1132 Skin Replacement Therapy For Chronic Non healing Wounds in The Outpatient Setting	
Q4158	Kerecis Omega3, per sq cm	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1132 Skin Replacement Therapy For Chronic Non healing Wounds in The Outpatient Setting	
Q4159	Affinity, per sq cm	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1132 Skin Replacement Therapy For Chronic Non healing Wounds in The Outpatient Setting	
Q4160	Nushield, per sq cm	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1132 Skin Replacement Therapy For Chronic Non healing Wounds in The Outpatient Setting	
Q4161	bio-ConneKt wound matrix, per sq cm	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1132 Skin Replacement Therapy For Chronic Non healing Wounds in The Outpatient Setting	
Q4162	WoundEx Flow, BioSkin Flow, 0.5 cc	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1132 Skin Replacement Therapy For Chronic Non healing Wounds in The Outpatient Setting	
Q4163	WoundEx, BioSkin, per sq cm	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1132 Skin Replacement Therapy For Chronic Non healing Wounds in The Outpatient Setting	
Q4201	Matrion, per sq cm	Prior authorization is required.		
Q4204	XWRAP, per sq cm	Prior authorization is required.		
Q4205	Membrane Graft or Membrane Wrap, per sq cm	Prior authorization is required.		
Q4208	Novafix, per sq cm	Prior authorization is required.		
Q4209	SurGraft, per sq cm	Prior authorization is required.		
Q4210	Axolotl Graft or Axolotl DualGraft, per sq cm	Prior authorization is required.		
Q4211	Amnion Bio or AxoBioMembrane, per sq cm	Prior authorization is required.		
Q4214	Cellesta Cord, per sq cm	Prior authorization is required.		
Q4216	Artacent Cord, per sq cm	Prior authorization is required.		
Q4217	WoundFix, BioWound, WoundFix Plus, BioWound Plus, WoundFix Xplus or BioWound Xplus, per sq cm	Prior authorization is required.		
Q4218	SurgiCORD, per sq cm	Prior authorization is required.		

Q4219	SurgiGRAFT-DUAL, per sq cm	Prior authorization is required.		
Q4221	Amnio Wrap2, per sq cm	Prior authorization is required.		
Q4227	AmnioCoreTM, per sq cm	Prior authorization is required.		
Q4229	Cogenex Amniotic Membrane, per sq cm	Prior authorization is required.		
Q4230	Cogenex Flowable Amnion, per 0.5 cc	Prior authorization is required.		
Q4231	Corplex P, per cc	Prior authorization is required.		
Q4232	Corplex, per sq cm	Prior authorization is required.		
Q4233	SurFactor or NuDyn, per 0.5 cc	Prior authorization is required.		
Q4234	XCellerate, per sq cm	Prior authorization is required.		
Q4235	AMNIOREPAIR or AltiPly, per sq cm	Prior authorization is required.		
Q4237	Cryo-Cord, per sq cm	Prior authorization is required.		
Q4239	Amnio-Maxx or Amnio-Maxx Lite, per sq cm	Prior authorization is required.		
Q4240	CoreCyte, for topical use only, per 0.5 cc	Prior authorization is required.		
Q4241	PolyCyte, for topical use only, per 0.5 cc	Prior authorization is required.		
Q4242	AmnioCyte Plus, per 0.5 cc	Prior authorization is required.		
Q4244	Procenta, per 200 mg	Prior authorization is required.		
Q4245	AmnioText, per cc	Prior authorization is required.		
Q4246	CoreText or ProText, per cc	Prior authorization is required.		
Q4247	Amniotext patch, per sq cm	Prior authorization is required.		
Q4248	Dermacyte Amniotic Membrane Allograft, per sq cm	Prior authorization is required.		
Q4249	AMNIPLY, for topical use only, per sq cm	Prior authorization is required.		
Q4250	AmnioAmp-MP, per sq cm	Prior authorization is required.		
Q4254	Novafix DL, per sq cm	Prior authorization is required.		
Q4255	REGUaRD, for topical use only, per sq cm	Prior authorization is required.		
Q5009	Hospice or home health care provided in place not otherwise specified (NOS)	Prior authorization is required.		
Q5131	Injection, adalimumab-aacf (idacio), biosimilar, 20 mg	Prior authorization is required.		
Q9991	Injection, buprenorphine extended-release (sublocade), **less than or equal to 100 mg**	Prior authorization is required.		
Q9992	Injection, buprenorphine extended-release (sublocade), **greater than 100 mg**	Prior authorization is required.		
S0013	Esketamine, nasal spray, 1 mg	Prior authorization is required.		
S0189	Testosterone pellet, 75 mg	Prior authorization is required.		
S0194	Dialysis/stress vitamin supplement, oral, 100 capsules	Prior authorization is required. Coverage is limited to DSHP+LTSS members who have been diagnosed with HIV/AIDS (B20, B97.35, Z21)		
S0199	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	Prior authorization is required. Elective abortions are not covered.		
S0215	Nonemergency transportation; mileage, per mile	Reference policies for additional information. the DMMA Provider Portal. https://medicaid.dhss.delaware.gov		
S0500	Disposable contact lens, per lens	Coverage is managed by Davis Vision		
S0512	Daily wear specialty contact lens, per lens	Coverage is managed by Davis Vision		
S0800	Laser in situ keratomileusis (LASIK)	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service.		
S0810	Photorefractive keratectomy (PRK)	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service.		
S1001	DELUXE ITEM PATIENT AWARE	Prior authorization is required when the billed charges are greater than $500.		
S1002	CUSTOMIZED ITEM	Prior authorization is required when the billed charges are greater than $500.		
S1015	IV TUBING EXTENSION SET	Prior authorization is required when the billed charges are greater than $500.		
S1016	NON-PVC IV ADMN SET RX NOT STABLE	Prior authorization is required when the billed charges are greater than $500.		
S1030	CONT NONINVAS GLU MON DEVC PURCHASE	Prior authorization is required when the billed charges are greater than $500.		
S1031	CONT NONINVAS GLU MON DEVC RENTAL	Prior authorization is required when the billed charges are greater than $500.		
S1034	ARTIF PANC DEVC SYS CMNCT ALL DEVC	Prior authorization is required when the billed charges are greater than $500.		
S1035	SNSR;INVASV DSPBL ART PANC DEVC SYS	Prior authorization is required when the billed charges are greater than $500.		
S1036	TRANSMTTR;EXT USE ART PANC DEVC SYS	Prior authorization is required when the billed charges are greater than $500.		
S1037	RECVER; EXT USE ARTIF PANC DEVC SYS	Prior authorization is required when the billed charges are greater than $500.		
S2053	Transplantation of small intestine and liver allografts	Prior authorization is required.		
S2054	Transplantation of multivisceral organs	Prior authorization is required.		
S2060	Lobar lung transplantation	Prior authorization is required.		
S2061	Donor lobectomy (lung) for transplantation, living donor	Prior authorization is required.		
S2065	Simultaneous pancreas kidney transplantation	Prior authorization is required.		
S2083	Adjustment of gastric band diameter via subcutaneous port by injection or aspiration of saline	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1004 Bariatric Surgery	
S2102	Islet cell tissue transplant from pancreas; allogeneic	Prior authorization is required.		
S2150	Bone marrow or blood-derived stem cells (peripheral or umbilical), allogeneic or autologous, harvesting, transplantation and related complications; including: pheresis and cell preparation/storage; marrow ablative therapy; drugs, supplies, hospitalization with outpatient follow-up; medical/surgical, diagnostic, emergency and rehabilitative services; and the number of days of pre- and posttransplant care in the global definition	Prior authorization is required.		

S2152	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	Prior authorization is required.		
S2260	Induced abortion, 17 to 24 weeks	Prior authorization is required. Elective abortions are not covered.		
S2265	Induced abortion, 25 to 28 weeks	Prior authorization is required. Elective abortions are not covered.		
S2266	Induced abortion, 29 to 31 weeks	Prior authorization is required. Elective abortions are not covered.		
S2267	Induced abortion, 32 weeks or greater	Prior authorization is required. Elective abortions are not covered.		
S2405	Repair of sacrococcygeal teratoma in the fetus, procedure performed in utero	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1110 Fetal Surgery for Prenatally Diagnosed Malformations	
S3854	Gene expression profiling panel for use in the management of breast cancer treatment	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1210 Oncologic Genetic Testing Panels	
S5101	Day care services, adult; per half day	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.		
S5101-U1	Day care services, adult; per half day-Enhanced Services	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.		
S5105	Day care services, center-based; services not included in program fee, per diem	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.		
S5105-U1	Day care services, center-based; services not included in program fee, per diem-Enhanced Services	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.		
S5120	Chore services; per 15 minutes	Prior authorization is required. Coverage is limited to DSHP+LTSS members.		
S5125	Attendant care services; per 15 minutes	Prior authorization is required. Coverage is limited to DSHP+LTSS members.		
S5130	Self-Directed Attendant Care Services, per 15 minutes	Prior authorization is required. Reference policies for additional information.	HHO-DE-RP-1133 Self-Directed Attendant Care-Non LTSS	
S5150	Unskilled respite care, not hospice; per 15 minutes	Prior authorization is required. Reference policies for additional information.	HHO-DE-RP-1135 Respite Care-Pediatric	
S5151	Unskilled respite care, not hospice; per diem	Prior authorization is required. Reference policies for additional information.	HHO-DE-RP-1135 Respite Care-Pediatric	
S5160	Emergency response system; installation and testing	Prior authorization is required. Coverage is limited to DSHP+LTSS members who do not reside in an assisted living or nursing facility.		
S5161	Emergency response system; service fee, per month (excludes installation and testing)	Prior authorization is required. Coverage is limited to DSHP+LTSS members who do not reside in an assisted living or nursing facility.		
S5162	Emergency response system; purchase only	Prior authorization is required. Coverage is limited to DSHP+LTSS members who do not reside in an assisted living or nursing facility.		
S5165	Home modifications; per service	Prior authorization is required. Coverage is limited to DSHP+LTSS members who do not reside in an assisted living or nursing facility.		
S5170	Home delivered meals, including preparation; per meal (fresh)	Prior authorization is required. Coverage is limited to two meals per day.		
S5170-ET	Home delivered meals, including preparation; per meal (emergency meal)	Prior authorization is required. Coverage is limited to two meals per day.		
S5170-U1	Home delivered meals, including preparation; per meal (frozen)	Prior authorization is required. Coverage is limited to two meals per day.		
S8030	Scleral application of tantalum ring(s) for localization of lesions for proton beam therapy	Prior authorization is required.		
S8037	Magnetic resonance cholangiopancreato-graphy (MRCP)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
S8042	Magnetic Resonance Imaging (MRI), Low-Field	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
S8092	Electron Beam Computed Tomography (Also Known As Ultrafast CT, CINET)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
S8096	PORTABLE PEAK FLOW METER	Prior authorization is required when the billed charges are greater than $500.		
S8097	ASTHMA KIT	Prior authorization is required when the billed charges are greater than $500.		
S8100	HOLD CHAMB W/INHAL/NEBULIZR;NO MASK	Prior authorization is required when the billed charges are greater than $500.		
S8101	HOLD CHAMB W/INHAL/NEBULIZR; W/MASK	Prior authorization is required when the billed charges are greater than $500.		
S8110	PEAK EXPIRATORY FLOW RATE	Prior authorization is required when the billed charges are greater than $500.		
S8120	O2 CNTN GASEOUS 1 U = 1 CUBIC FOOT	Prior authorization is required when the billed charges are greater than $500.		
S8121	O2 CONTENTS LQD 1 U EQUALS 1 POUND	Prior authorization is required when the billed charges are greater than $500.		
S8130	INTERFERENTIAL CURR STIM 2 CHANNEL	Prior authorization is required when the billed charges are greater than $500.		
S8131	INTERFERENTIAL CURR STIM 4 CHANNEL	Prior authorization is required when the billed charges are greater than $500.		
S8185	FLUTTER DEVICE	Prior authorization is required when the billed charges are greater than $500.		
S8186	SWIVEL ADAPTOR	Prior authorization is required when the billed charges are greater than $500.		
S8189	TRACHEOSTOMY SUPPLY NOC	Prior authorization is required when the billed charges are greater than $500.		
S8210	MUCUS TRAP	Prior authorization is required when the billed charges are greater than $500.		
S8265	HABERMAN FEEDER CLEFT LIP/PALATE	Prior authorization is required when the billed charges are greater than $500.		
S8270	ENURESIS ALARM BUZZ&/VIBRATION DEVC	Prior authorization is required when the billed charges are greater than $500.		
S8301	INFECTION CONTROL SUPPLIES NOS	Prior authorization is required when the billed charges are greater than $500.		
S8415	SUPPLIES HOME DELIVERY OF INFANT	Prior authorization is required when the billed charges are greater than $500.		
S8420	GRADENT PRESS AID SLEEVE&GLOVE CSTM	Prior authorization is required when the billed charges are greater than $500.		
S8421	GRADENT PRESS AID SLV&GLOV RDY MADE	Prior authorization is required when the billed charges are greater than $500.		
S8422	GRADENT PRESS AID SLEEV CSTM MED WT	Prior authorization is required when the billed charges are greater than $500.		
S8423	GRADENT PRESS AID SLEEV CSTM HVY WT	Prior authorization is required when the billed charges are greater than $500.		
S8424	GRADENT PRESS AID SLEEVE READY MADE	Prior authorization is required when the billed charges are greater than $500.		
S8425	GRADENT PRESS AID GLOVE CSTM MED WT	Prior authorization is required when the billed charges are greater than $500.		
S8426	GRADENT PRESS AID GLOVE CSTM HVY WT	Prior authorization is required when the billed charges are greater than $500.		
S8427	GRADENT PRESS AID GLOVE READY MADE	Prior authorization is required when the billed charges are greater than $500.		

S8428	GRADENT PRESS AID GAUNTLET RDY MADE	Prior authorization is required when the billed charges are greater than $500.		
S8429	GRADIENT PRESSURE EXTERIOR WRAP	Prior authorization is required when the billed charges are greater than $500.		
S8430	PADDING COMPRESSION BANDAGE ROLL	Prior authorization is required when the billed charges are greater than $500.		
S8431	COMPRESSION BANDAGE ROLL	Prior authorization is required when the billed charges are greater than $500.		
S8450	SPLINT PREFABRICATED DIGIT	Prior authorization is required when the billed charges are greater than $500.		
S8451	SPLINT PREFABRICATED WRIST OR ANKLE	Prior authorization is required when the billed charges are greater than $500.		
S8452	SPLINT PREFABRICATED ELBOW	Prior authorization is required when the billed charges are greater than $500.		
S8460	CAMISOLE POST-MASTECTOMY	Prior authorization is required when the billed charges are greater than $500.		
S8490	INSULIN SYRINGES	Prior authorization is required when the billed charges are greater than $500.		
S8999	RESUSCITATION BAG	Prior authorization is required when the billed charges are greater than $500.		
S9001	HOME UTERIN MON W/WO ASSOC NRS SRVC	Prior authorization is required when the billed charges are greater than $500.		
S9007	ULTRAFILTRATION MONITOR	Prior authorization is required when the billed charges are greater than $500.		
S9123	Nursing care, in the home; by registered nurse, per hour	Prior authorization is required.		
S9124	Nursing care, in the home; by licensed practical nurse, per hour	Prior authorization is required.		
S9125	Respite care, in the home, per diem	Prior authorization is required. Reference policies for additional information.	HHO-DE-RP-1135 Respite Care-Pediatric	
S9433	MED FOOD NUTR ORAL 100% NUTR INTAKE	Prior authorization is required when the billed charges are greater than $500.		
S9434	MOD SOLID FOOD SUP INBORN ERR METAB	Prior authorization is required when the billed charges are greater than $500.		
S9435	MEDICAL FOODS INBORN ERRORS METAB	Prior authorization is required when the billed charges are greater than $500.		
S9470	Nutritional counseling, dietitian visit	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1133 Medical Nutrition Management Services	
S9988	Services provided as part of a Phase I clinical trial	Prior authorization is required. Reference policies for additional information.	HHO-DE-RP-DE-1141 Clinical Trial	
S9990	Services provided as part of a Phase II clinical trial	Prior authorization is required. Reference policies for additional information.	HHO-DE-RP-DE-1141 Clinical Trial	
S9991	Services provided as part of a Phase III clinical trial	Prior authorization is required. Reference policies for additional information.	HHO-DE-RP-DE-1141 Clinical Trial	
T1000	Private duty/independent nursing service(s), licensed, up to 15 minutes	Prior authorization is required.		
T1001	Nursing assessment/evaluation	Prior authorization is required.		
T1002	RN services, up to 15 minutes	Prior authorization is required.		
T1005	Respite care services, up to 15 minutes	Prior authorization is required. Reference policies for additional information.	HHO-DE-RP-1135 Respite Care-Pediatric	
T2001	Nonemergency transportation; patient attendant/escort	Reference policies for additional information. the DMMA Provider Portal. https://medicaid.dhss.delaware.gov		
T2002	Nonemergency transportation; per diem	Reference policies for additional information. the DMMA Provider Portal. https://medicaid.dhss.delaware.gov		
T2003	Nonemergency transportation; encounter/trip	Reference policies for additional information. the DMMA Provider Portal. https://medicaid.dhss.delaware.gov		
T2004	Nonemergency transport; commercial carrier, multipass	Reference policies for additional information. the DMMA Provider Portal. https://medicaid.dhss.delaware.gov		
T2005	Nonemergency transportation; stretcher van	Reference policies for additional information. the DMMA Provider Portal. https://medicaid.dhss.delaware.gov		
T2007	Transportation waiting time, air ambulance and nonemergency vehicle, one-half (1/2) hour increments	Reference policies for additional information. the DMMA Provider Portal. https://medicaid.dhss.delaware.gov		
T2020	Day habilitation, waiver; per diem	Prior authorization is required. Coverage is limited to DSHP+ LTSS members. Not available to members living in non-ABI assisted living and nursing facilities.		
T2028	Specialized supply, not otherwise specified, waiver	Prior authorization is required for billed charges greater than $500.		
T2029	Specialized medical equipment, not otherwise specified, waiver	Prior authorization is required for billed charges greater than $500.		
T2038	Community transition, waiver; per service	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.		
T2049	Nonemergency transportation; stretcher van, mileage; per mile	Reference policies for additional information. the DMMA Provider Portal. https://medicaid.dhss.delaware.gov		
T4521	Adult sized disposable incontinence product, brief/diaper, small, each	Prior authorization is required if more than 8 units are billed per day. Not a covered service for members ages 3 and younger.		
T4522	Adult sized disposable incontinence product, brief/diaper, medium, each	Prior authorization is required if more than 8 units are billed per day. Not a covered service for members under 4.		
T4523	Adult sized disposable incontinence product, brief/diaper, large, each	Prior authorization is required if more than 8 units are billed per day. Not a covered service for members under 4.		
T4524	Adult sized disposable incontinence product, brief/diaper, extra large, each	Prior authorization is required if more than 8 units are billed per day. Not a covered service for members under 4.		
T4525	Adult sized disposable incontinence product, protective underwear/pull-on, small size, each	Prior authorization is required if more than 8 units are billed per day. Not a covered service for members under 4.		
T4526	Adult sized disposable incontinence product, protective underwear/pull-on, medium size, each	Prior authorization is required if more than 8 units are billed per day. Not a covered service for members under 4.		
T4527	Adult sized disposable incontinence product, protective underwear/pull-on, large size, each	Prior authorization is required if more than 8 units are billed per day. Not a covered service for members under 4.		
T4528	Adult sized disposable incontinence product, protective underwear/pull-on, extra large size, each	Prior authorization is required if more than 8 units are billed per day. Not a covered service for members under 4.		
T4529	Pediatric sized disposable incontinence product, brief/diaper, small/medium size, each	Prior authorization is required if more than 8 units are billed per day. Not a covered service for members under 4.		

T4530	Pediatric sized disposable incontinence product, brief/diaper, large size, each	Prior authorization is required if more than 8 units are billed per day. Not a covered service for members under 4.		
T4531	Pediatric sized disposable incontinence product, protective underwear/pull-on, small/medium size, each	Prior authorization is required if more than 8 units are billed per day. Not a covered service for members under 4.		
T4532	Pediatric sized disposable incontinence product, protective underwear/pull-on, large size, each	Prior authorization is required if more than 8 units are billed per day. Not a covered service for members under 4.		
T4533	Youth sized disposable incontinence product, brief/diaper, each	Prior authorization is required if more than 8 units are billed per day. Not a covered service for members under 4.		
T4534	Youth sized disposable incontinence product, protective underwear/pull-on, each	Prior authorization is required if more than 8 units are billed per day. Not a covered service for members under 4.		
T4535	Disposable liner/shield/guard/pad/undergarment, for incontinence, each	Prior authorization is required if more than 8 units are billed per day.		
T4541	Incontinence product, disposable underpad, large, each	Prior authorization is required if more than 8 units are billed per day.		
T4542	Incontinence product, disposable underpad, small size, each	Prior authorization is required if more than 8 units are billed per day.		
T4543	Adult sized disposable incontinence product, protective brief/diaper, above extra large, each	Prior authorization is required if more than 8 units are billed per day. Not a covered service for members under 4.		
T4544	Adult sized disposable incontinence product, protective underwear/pull-on, above extra large, each	Prior authorization is required if more than 8 units are billed per day. Not a covered service for members under 4.		
T4545	Incontinence product, disposable, penile wrap, each	Prior authorization is required if more than 8 units are billed per day.		
T5999	Supply, not otherwise specified	Prior authorization is required for billed charges greater than $500.		
V2020	Frames, purchases	Coverage is managed by Davis Vision		
V2025	Deluxe frame	Coverage is managed by Davis Vision		
V2100	Sphere, single vision, plano to plus or minus 4.00, per lens	Coverage is managed by Davis Vision		
V2101	Sphere, single vision, plus or minus 4.12 to plus or minus 7.00d, per lens	Coverage is managed by Davis Vision		
V2102	Sphere, single vision, plus or minus 7.12 to plus or minus 20.00d, per lens	Coverage is managed by Davis Vision		
V2103	Spherocylinder, single vision, plano to plus or minus 4.00d sphere, 0.12 to 2.00d cylinder, per lens	Coverage is managed by Davis Vision		
V2104	Spherocylinder, single vision, plano to plus or minus 4.00d sphere, 2.12 to 4.00d cylinder, per lens	Coverage is managed by Davis Vision		
V2105	Spherocylinder, single vision, plano to plus or minus 4.00d sphere, 4.25 to 6.00d cylinder, per lens	Coverage is managed by Davis Vision		
V2106	Spherocylinder, single vision, plano to plus or minus 4.00d sphere, over 6.00d cylinder, per lens	Coverage is managed by Davis Vision		
V2107	Spherocylinder, single vision, plus or minus 4.25 to plus or minus 7.00 sphere, 0.12 to 2.00d cylinder, per lens	Coverage is managed by Davis Vision		
V2108	Spherocylinder, single vision, plus or minus 4.25d to plus or minus 7.00d sphere, 2.12 to 4.00d cylinder, per lens	Coverage is managed by Davis Vision		
V2109	Spherocylinder, single vision, plus or minus 4.25 to plus or minus 7.00d sphere, 4.25 to 6.00d cylinder, per lens	Coverage is managed by Davis Vision		
V2110	Spherocylinder, single vision, plus or minus 4.25 to 7.00d sphere, over 6.00d cylinder, per lens	Coverage is managed by Davis Vision		
V2111	Spherocylinder, single vision, plus or minus 7.25 to plus or minus 12.00d sphere, 0.25 to 2.25d cylinder, per lens	Coverage is managed by Davis Vision		
V2112	Spherocylinder, single vision, plus or minus 7.25 to plus or minus 12.00d sphere, 2.25d to 4.00d cylinder, per lens	Coverage is managed by Davis Vision		
V2113	Spherocylinder, single vision, plus or minus 7.25 to plus or minus 12.00d sphere, 4.25 to 6.00d cylinder, per lens	Coverage is managed by Davis Vision		
V2114	Spherocylinder, single vision, sphere over plus or minus 12.00d, per lens	Coverage is managed by Davis Vision		
V2115	Lenticular (myodisc), per lens, single vision	Coverage is managed by Davis Vision		
V2118	Aniseikonic lens, single vision	Coverage is managed by Davis Vision		
V2121	Lenticular lens, per lens, single	Coverage is managed by Davis Vision		
V2199	Not otherwise classified, single vision lens	Coverage is managed by Davis Vision		
V2200	Sphere, bifocal, plano to plus or minus 4.00d, per lens	Coverage is managed by Davis Vision		
V2201	Sphere, bifocal, plus or minus 4.12 to plus or minus 7.00d, per lens	Coverage is managed by Davis Vision		
V2202	Sphere, bifocal, plus or minus 7.12 to plus or minus 20.00d, per lens	Coverage is managed by Davis Vision		
V2203	Spherocylinder, bifocal, plano to plus or minus 4.00d sphere, 0.12 to 2.00d cylinder, per lens	Coverage is managed by Davis Vision		
V2204	Spherocylinder, bifocal, plano to plus or minus 4.00d sphere, 2.12 to 4.00d cylinder, per lens	Coverage is managed by Davis Vision		
V2205	Spherocylinder, bifocal, plano to plus or minus 4.00d sphere, 4.25 to 6.00d cylinder, per lens	Coverage is managed by Davis Vision		
V2206	Spherocylinder, bifocal, plano to plus or minus 4.00d sphere, over 6.00d cylinder, per lens	Coverage is managed by Davis Vision		
V2207	Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 0.12 to 2.00d cylinder, per lens	Coverage is managed by Davis Vision		
V2208	Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 2.12 to 4.00d cylinder, per lens	Coverage is managed by Davis Vision		
V2209	Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 4.25 to 6.00d cylinder, per lens	Coverage is managed by Davis Vision		
V2210	Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00d sphere, over 6.00d cylinder, per lens	Coverage is managed by Davis Vision		
V2211	Spherocylinder, bifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 0.25 to 2.25d cylinder, per lens	Coverage is managed by Davis Vision		

V2212	Spherocylinder, bifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 2.25 to 4.00d cylinder, per lens	Coverage is managed by Davis Vision		
V2213	Spherocylinder, bifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 4.25 to 6.00d cylinder, per lens	Coverage is managed by Davis Vision		
V2214	Spherocylinder, bifocal, sphere over plus or minus 12.00d, per lens	Coverage is managed by Davis Vision		
V2215	Lenticular (myodisc), per lens, bifocal	Coverage is managed by Davis Vision		
V2218	Aniseikonic, per lens, bifocal	Coverage is managed by Davis Vision		
V2219	Bifocal seg width over 28mm	Coverage is managed by Davis Vision		
V2220	Bifocal add over 3.25d	Coverage is managed by Davis Vision		
V2221	Lenticular lens, per lens, bifocal	Coverage is managed by Davis Vision		
V2299	Specialty bifocal (by report)	Coverage is managed by Davis Vision		
V2300	Sphere, trifocal, plano to plus or minus 4.00d, per lens	Coverage is managed by Davis Vision		
V2301	Sphere, trifocal, plus or minus 4.12 to plus or minus 7.00d per lens	Coverage is managed by Davis Vision		
V2302	Sphere, trifocal, plus or minus 7.12 to plus or minus 20.00, per lens	Coverage is managed by Davis Vision		
V2304	Spherocylinder, trifocal, plano to plus or minus 4.00d sphere, 2.25 to 4.00d cylinder, per lens	Coverage is managed by Davis Vision		
V2305	Spherocylinder, trifocal, plano to plus or minus 4.00d sphere, 4.25 to 6.00 cylinder, per lens	Coverage is managed by Davis Vision		
V2306	Spherocylinder, trifocal, plano to plus or minus 4.00d sphere, over 6.00d cylinder, per lens	Coverage is managed by Davis Vision		
V2307	Spherocylinder, trifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 0.12 to 2.00d cylinder, per lens	Coverage is managed by Davis Vision		
V2308	Spherocylinder, trifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 2.12 to 4.00d cylinder, per lens	Coverage is managed by Davis Vision		
V2309	Spherocylinder, trifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 4.25 to 6.00d cylinder, per lens	Coverage is managed by Davis Vision		
V2310	Spherocylinder, trifocal, plus or minus 4.25 to plus or minus 7.00d sphere, over 6.00d cylinder, per lens	Coverage is managed by Davis Vision		
V2311	Spherocylinder, trifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 0.25 to 2.25d cylinder, per lens	Coverage is managed by Davis Vision		
V2312	Spherocylinder, trifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 2.25 to 4.00d cylinder, per lens	Coverage is managed by Davis Vision		
V2313	Spherocylinder, trifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 4.25 to 6.00d cylinder, per lens	Coverage is managed by Davis Vision		
V2314	Spherocylinder, trifocal, sphere over plus or minus 12.00d, per lens	Coverage is managed by Davis Vision		
V2315	Lenticular, (myodisc), per lens, trifocal	Coverage is managed by Davis Vision		
V2318	Aniseikonic lens, trifocal	Coverage is managed by Davis Vision		
V2319	Trifocal seg width over 28 mm	Coverage is managed by Davis Vision		
V2320	Trifocal add over 3.25d	Coverage is managed by Davis Vision		
V2321	Lenticular lens, per lens, trifocal	Coverage is managed by Davis Vision		
V2399	Specialty trifocal (by report)	Coverage is managed by Davis Vision		
V2500	Contact lens, PMMA, spherical, per lens	Coverage is managed by Davis Vision		
V2501	Contact lens, PMMA, toric or prism ballast, per lens	Coverage is managed by Davis Vision		
V2502	Contact lens PMMA, bifocal, per lens	Coverage is managed by Davis Vision		
V2503	Contact lens, PMMA, color vision deficiency, per lens	Coverage is managed by Davis Vision		
V2510	Contact lens, gas permeable, spherical, per lens	Coverage is managed by Davis Vision		
V2511	Contact lens, gas permeable, toric, prism ballast, per lens	Coverage is managed by Davis Vision		
V2512	Contact lens, gas permeable, bifocal, per lens	Coverage is managed by Davis Vision		
V2513	Contact lens, gas permeable, extended wear, per lens	Coverage is managed by Davis Vision		
V2520	Contact lens, hydrophilic, spherical, per lens	Coverage is managed by Davis Vision		
V2521	Contact lens, hydrophilic, toric, or prism ballast, per lens	Coverage is managed by Davis Vision		
V2522	Contact lens, hydrophilic, bifocal, per lens	Coverage is managed by Davis Vision		
V2523	Contact lens, hydrophilic, extended wear, per lens	Coverage is managed by Davis Vision		
V2530	Contact lens, scleral, gas impermeable, per lens (for contact lens modification, see 92325)	Coverage is managed by Davis Vision		
V2531	Contact lens, scleral, gas permeable, per lens (for contact lens modification, see 92325)	Coverage is managed by Davis Vision		
V2599	Contact lens, other type	Coverage is managed by Davis Vision		
V2784	Lens, polycarbonate or equal, any index, per lens	Coverage is managed by Davis Vision		
V2790	Amniotic membrane for surgical reconstruction, per procedure	Prior authorization is required.		
V5030	HEAR AID MONAURL BDY WRN AIR CONDCT	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1190 External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing and HHO-DE-MP-1140 Coverage for Hearing Aids	
V5040	HEAR AID MONAURL BDY WORN BN CONDCT	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1190 External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing and HHO-DE-MP-1140 Coverage for Hearing Aids	
V5050	HEARING AID MONAURAL IN THE EAR	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1190 External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing and HHO-DE-MP-1140 Coverage for Hearing Aids	

V5060	HEARING AID MONAURAL BEHIND THE EAR	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1190 External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing and HHO-DE-MP-1140 Coverage for Hearing Aids	
V5070	GLASSES AIR CONDUCTION	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1190 External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing and HHO-DE-MP-1140 Coverage for Hearing Aids	
V5080	GLASSES BONE CONDUCTION	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1190 External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing and HHO-DE-MP-1140 Coverage for Hearing Aids	
V5090	Dispensing fee, unspecified hearing aid	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1140 Coverage for Hearing Aids	
V5095	SEMI-IMPL MID EAR HEARING PROSTH	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1190 External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing and HHO-DE-MP-1140 Coverage for Hearing Aids	
V5100	HEARING AID BILATERAL BODY WORN	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1190 External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing and HHO-DE-MP-1140 Coverage for Hearing Aids	
V5120	BINAURAL BODY	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1190 External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing and HHO-DE-MP-1140 Coverage for Hearing Aids	
V5130	BINAURAL IN THE EAR	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1190 External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing and HHO-DE-MP-1140 Coverage for Hearing Aids	
V5140	BINAURAL BEHIND THE EAR	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1190 External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing and HHO-DE-MP-1140 Coverage for Hearing Aids	
V5150	BINAURAL GLASSES	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1190 External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing and HHO-DE-MP-1140 Coverage for Hearing Aids	
V5171	HA CONTRALAT RTE DVC MONAURAL ITE	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1190 External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing and HHO-DE-MP-1140 Coverage for Hearing Aids	
V5172	HA CONTRALAT RTE DVC MONAURAL ICT	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1190 External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing and HHO-DE-MP-1140 Coverage for Hearing Aids	
V5181	HA CONTRALAT RTE DVC MONAURAL BTE	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1190 External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing and HHO-DE-MP-1140 Coverage for Hearing Aids	
V5190	HA CONTRALAT RTE MONAURAL GLASSES	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1140 Coverage for Hearing Aids	
V5211	HA CONTRALAT RS BINAURAL ITE/ITE	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1190 External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing and HHO-DE-MP-1140 Coverage for Hearing Aids	
V5212	HA CONTRALAT RS BINAURAL ITE/ITE	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1190 External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing and HHO-DE-MP-1140 Coverage for Hearing Aids	
V5213	HA CONTRA RTE SYS BINAURAL ITE/ITC	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1190 External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing and HHO-DE-MP-1140 Coverage for Hearing Aids	
V5214	HA CONTRA ROUT SYS BINAURAL ITE/BTE	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1190 External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing and HHO-DE-MP-1140 Coverage for Hearing Aids	
V5215	HA CONTRA ROUT SYS BINAURAL ITC/ITC	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1190 External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing and HHO-DE-MP-1140 Coverage for Hearing Aids	
V5221	HA CONTRA ROUT SYS BINAURAL ITC/BTE	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1190 External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing and HHO-DE-MP-1140 Coverage for Hearing Aids	
V5230	HA CONTRALAT RTE SYS BINAUR GLASSES	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1190 External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing and HHO-DE-MP-1140 Coverage for Hearing Aids	
V5242	HEARING AID ANALOG MONAURAL CIC	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1190 External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing and HHO-DE-MP-1140 Coverage for Hearing Aids	
V5243	HEARING AID ANALOG MONAURAL ITC	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1190 External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing and HHO-DE-MP-1140 Coverage for Hearing Aids	
V5244	HEARING AID PROG ANALOG MONAURL CIC	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1190 External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing and HHO-DE-MP-1140 Coverage for Hearing Aids	

V5245	HEARING AID PROG ANALOG MONAURL ITC	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1190 External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing and HHO-DE-MP-1140 Coverage for Hearing Aids	
V5246	HEARING AID PROG ANALOG MONAURL ITE	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1190 External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing and HHO-DE-MP-1140 Coverage for Hearing Aids	
V5247	HEARING AID PROG ANALOG MONAURL BTE	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1190 External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing and HHO-DE-MP-1140 Coverage for Hearing Aids	
V5248	HEARING AID ANALOG BINAURAL CIC	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1190 External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing and HHO-DE-MP-1140 Coverage for Hearing Aids	
V5249	HEARING AID ANALOG BINAURAL ITC	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1190 External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing and HHO-DE-MP-1140 Coverage for Hearing Aids	
V5250	HEARING AID PROG ANALOG BINAURL CIC	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1190 External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing and HHO-DE-MP-1140 Coverage for Hearing Aids	
V5251	HEARING AID PROG ANALOG BINAURL ITC	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1190 External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing and HHO-DE-MP-1140 Coverage for Hearing Aids	
V5252	HEARING AID PROG BINAURAL ITE	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1190 External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing and HHO-DE-MP-1140 Coverage for Hearing Aids	
V5253	HEARING AID PROG BINAURAL BTE	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1190 External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing and HHO-DE-MP-1140 Coverage for Hearing Aids	
V5254	HEARING AID DIGITAL MONAURAL CIC	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1190 External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing and HHO-DE-MP-1140 Coverage for Hearing Aids	
V5255	HEARING AID DIGITAL MONAURAL ITC	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1190 External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing and HHO-DE-MP-1140 Coverage for Hearing Aids	
V5256	HEARING AID DIGITAL MONAURAL ITE	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1190 External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing and HHO-DE-MP-1140 Coverage for Hearing Aids	
V5257	HEARING AID DIGITAL MONAURAL BTE	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1190 External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing and HHO-DE-MP-1140 Coverage for Hearing Aids	
V5258	HEARING AID DIGITAL BINAURAL CIC	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1190 External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing and HHO-DE-MP-1140 Coverage for Hearing Aids	
V5259	HEARING AID DIGITAL BINAURAL ITC	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1190 External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing and HHO-DE-MP-1140 Coverage for Hearing Aids	
V5260	HEARING AID DIGITAL BINAURAL ITE	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1190 External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing and HHO-DE-MP-1140 Coverage for Hearing Aids	
V5261	HEARING AID DIGITAL BINAURAL BTE	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1190 External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing and HHO-DE-MP-1140 Coverage for Hearing Aids	
V5262	HEARING AID DISPBL TYPE MONAURAL	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1190 External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing and HHO-DE-MP-1140 Coverage for Hearing Aids	
V5263	HEARING AID DISPBL TYPE BINAURAL	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1190 External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing and HHO-DE-MP-1140 Coverage for Hearing Aids	
V5264	EAR MOLD/INSERT NOT DISPBL ANY TYPE	Prior authorization is required when the billed charges are greater than $500.		
V5265	EAR MOLD/INSERT DISPOSABLE ANY TYPE	Prior authorization is required when the billed charges are greater than $500.		
V5266	BATTERY FOR USE IN HEARING DEVICE	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1140 Coverage for Hearing Aids	
V5267	HA/ALD/SUPP/ACCESS NOT O/W SPEC	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1140 Coverage for Hearing Aids	
V5268	ASST LISTENING DEVICE TEL AMP TYPE	Prior authorization is required when the billed charges are greater than $500.		
V5269	ASST LISTENING DEVICE ALERTING TYPE	Prior authorization is required when the billed charges are greater than $500.		
V5270	ASST LISTENING DEVICE TV AMP TYPE	Prior authorization is required when the billed charges are greater than $500.		
V5271	ASST LISTEN DEVC TV CAPTION DECODER	Prior authorization is required when the billed charges are greater than $500.		
V5272	ASSISTIVE LISTENING DEVICE TDD	Prior authorization is required when the billed charges are greater than $500.		
V5273	ASSTIVE LISTEN DEVC W/COCHLEAR IMPL	Prior authorization is required when the billed charges are greater than $500.		

V5274	ASSISTIVE LEARNING DEVICE NOS	Prior authorization is required when the billed charges are greater than $500.		
V5275	EAR IMPRESSION EACH	Prior authorization is required when the billed charges are greater than $500.		
V5281	ALD PERS FM/DM SYS MONAURL ANY TYPE	Prior authorization is required when the billed charges are greater than $500.		
V5282	ALD PERS FM/DM SYS BINAURL ANY TYPE	Prior authorization is required when the billed charges are greater than $500.		
V5283	ALD PERS FM/DM NCK LOOP INDUCT RECV	Prior authorization is required when the billed charges are greater than $500.		
V5284	ALD PERS FM/DM EAR LEVEL RECEIVER	Prior authorization is required when the billed charges are greater than $500.		
V5285	ALD PERS FM/DM DIR AUDIO INPUT RECV	Prior authorization is required when the billed charges are greater than $500.		
V5286	ALD PERS BLUE TOOTH FM/DM RECEIVR	Prior authorization is required when the billed charges are greater than $500.		
V5287	ALD PERS FM/DM RECEIVER NOS	Prior authorization is required when the billed charges are greater than $500.		
V5288	ALD PERS FM/DM TRANSMITTER ALD	Prior authorization is required when the billed charges are greater than $500.		
V5289	ALD PERS FM/DM ADPTR/BOOT CPLG RECV	Prior authorization is required when the billed charges are greater than $500.		
V5290	ALD TRANSMITT MICROPHONE ANY TYPE	Prior authorization is required when the billed charges are greater than $500.		
V5298	HEARING AID NOC	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1190 External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing and HHO-DE-MP-1140 Coverage for Hearing Aids	
V5299	Hearing service, miscellaneous	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1190 External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing	
V5336	REPR/MOD AUGMENTATIV CMNCT SYS/DEVC	Prior authorization is required for billed charges greater than $500. Reference policies for additional information.	HHO-DE-MP-1140 Coverage for Hearing Aids	